

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39501

Physician  
/Medical  
Examiner

Funeral  
Director

|   |                               |   |  |  |  |  |  |
|---|-------------------------------|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br>MINNIE LOU DODSON   |                               |   |  | 2. Date of Death<br>Month 12 Day 08 Year 97  |  | 3. Time of Death<br>10:31AM  |  |
| 4a. Facility Name (If not institution, give street and number)<br>PRINCE GEORGES HOSPITAL   |                               |   |  | 4b. City, Town, or Location of Death<br>CHEVERLEY  |  | 4c. County of Death<br>PRINCE GEORGES  |  |
| 5. Social Security Number<br>283-36-3030  |                               | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>62 Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                     | 8. Date of Birth (Month, Day, Year)<br>10-22-35  |  |
| Usual Residence of Decedent   |                               |   |  | 9. Birthplace (State or Foreign Country)<br>SOUTH CAROLINA   |  |  |  |
| 10a. State<br>MD  | 10b. County<br>PRINCE GEORGES |   | 10c. City, Town or Location<br>HYATTSVILLE   |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 10e. Street and Number<br>2201 WOODBURY CT.   |                               |   | 10f. Zip Code<br>20782   |  | 10g. Citizen of What Country?<br>UNITED STATES     |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |                               | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black                                   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12th Grade  |                               |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Detective |  | 16b. Kind of Business/Industry<br>Ames Dept. Store |  |  |
| 17. Father's Name (First, Middle, Last)<br>Prince Ellerbe   |                               |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Ethel Lee McFall  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>BRYANT DODSON/SON   |                               |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2201 WOODBURY CT, HYATTSVILLE, MD 20782   |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |                               | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>MARYLAND NATIONAL   |  | Data<br>12/13  |  | 20c. Location - City or Town, State<br>LAUREL, MD  |  |
| 21. Signature of Funeral Service Licensee<br><i>Edward M. Dudley</i>  |                               | 22. Name and Address of Facility<br>E.M. DUDLEY FUNERAL HOME<br>3200 Rhode Island Ave. Mt. Rainier, MD 20712  |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. <i>ind stage leukemia</i><br>Due to (or as a consequence of):<br>b. _____ Due to (or as a consequence of):<br>c. _____ Due to (or as a consequence of):<br>d. _____<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                               |   |  | Approximate Interval Between Onset and Death<br>3915   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>DDM, HCV, DSD, cancer</i><br><i>leukemia, M.P.S. &amp; pneumonia</i><br><i>thrombocytopenia, leukopenia</i>  |                               |   |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |                               | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |                               | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No    |  |
| 28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)  |                               |   |  | 28d. Describe how injury occurred  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                               |   |  |  |  |  |  |
| 29a. Certify (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |                               |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br><i>Lewis Dennis</i>  |                               | 29c. License number<br>D01499   |  | 29d. Date signed (Month, Day, Year)<br>Dec. 8, 1997  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>LEWIS DENNIS, M.D. 6201 GREENBELT ROAD, GREENBELT, MARYLAND 20740   |                               |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>DEC 17 1997  |                               | 32. Registrar's Signature<br><i>John A. ...</i>   |  |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39502

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Richard George

Dash, Sr.

2. Date of Death  
Month Day Year

December 6 1997

3. Time of Death

9:10PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

543 Old Oak Road

4b. City, Town, or Location of Death

Severn

4c. County of Death

Anne Arundel

5. Social Security Number

220-12-7967

6. Sex

10M 20F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

February 27, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Severn

10d. Inside City Limits

10 Yes 20 No

10e. Street and Number

543 Old Oak Road

10f. Zip Code

21144

10g. Citizen of What Country?

U.S.A.

11. Marital Status

10 Never Married 20 Married  
30 Widowed 40 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
10 Yes 20 No  
If Yes, Give Year or Dates: 1944-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 20 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Contract Specialist

16b. Kind of Business/Industry

U.S. Navy

17. Father's Name (First, Middle, Last)

Lewis Dash

18. Mother's Name (First, Middle, Maiden Surname)

Mary Louise Valentine

19a. Informant's Name/Relationship (Type, Print)

Mildred Dash (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

543 Old Oak Road, Severn, Maryland 21144

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State  
40 Donation 50 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Memorial Park 12/9/97 Glen Burnie, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Singleton Funeral Home  
1 Second Avenue, S.W., Glen Burnie, Md. 21061

23. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Metastatic Adenocarcinoma of the Lung

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

14 mos

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy performed?

10 Yes 20 No

24b. Were autopsy findings available prior to completion of cause of death?

10 Yes 20 No

25. Was case referred to medical examiner?

10 Yes 20 No

26. Place of Death (Check only one)

Hospital:

10 Inpatient

20 ER/Outpatient

30 DOA

Other:

40 Nursing Home

50 Residence

80 Other (Specify)

27. Manner of Death

10 Natural 50 Pending investigation  
20 Accident 60 Could not be determined  
30 Suicide  
40 Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

10 Yes 20 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D31551

29d. Date signed (Month, Day, Year)

December 8, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Russell A. DeLuca, MD 1606 S. Craig Highway, Suite 602, Glen Burnie, Md 21061

31. Date filed (Month, Day, Year)

DEC 11 1997

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39503

|   |  |  |  |  |   |  |   |  |
|---|--|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>VALERIE P. DUNKLEY</b>  |  |  |  | 2. Date of Death<br>Month Day Year<br><b>DEC. 8 1997</b>  |  | 3. Time of Death<br><b>1653</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>ANNE ARUNDEL MEDICAL CENTER</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>ANNAPOLIS</b>  |  | 4c. County of Death<br><b>ANNE ARUNDEL</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>215-92-3472</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>44</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>NOV. 18 1953</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>WEST INDIES</b>   |  | 10a. State<br><b>MARYLAND</b>  |  | 10b. County<br><b>ANNE ARUNDEL</b>  |  | 10c. City, Town or Location<br><b>ANNAPOLIS</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 10e. Street and Number<br><b>1312 WASHINGTON DRIVE</b>  |  | 10f. Zip Code<br><b>21403</b>   |  |
|   | 10g. Citizen of What Country?<br><b>US</b>   |  |  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>3 yrs.</b>      |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>ACCOUNT EXECUTIVE</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>BASKIN FINANCIAL</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>LLOYD ARRINDELL</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>CATHERINE EUGENIA</b>   |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>WINSTON DUNKLEY (HUSBAND)</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1312 WASHINGTON DRIVE ANNAPOLIS, MD. 21403</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>METRO CREMATORY</b>  |  | 20c. Location - City or Town, State<br><b>12/12/97 BALTIMORE, MD.</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Larry H. Reese</b>   |  |  |  | 22. Name and Address of Facility<br><b>WM. REESE &amp; SONS MORTUARY, P.A.<br/>821 WEST ST. ANNAPOLIS, MD. 21401</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Cardiopulmonary Arrest</b><br>Due to (or as a consequence of):<br><b>Pulmonary Embolus</b><br>Due to (or as a consequence of):<br><b>Large Left Middle Cerebral Artery Stroke</b><br>Due to (or as a consequence of):<br><b>Hypertension</b> |  |  |  | Approximate Interval Between Onset and Death<br><b>22 minutes</b><br><b>25 minutes</b><br><b>3 days</b><br><b>5 years</b>   |  |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Type II Diabetes mellitus</b><br><b>Obesity</b>   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  |  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  |
|   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                    |  |  |  | 29b. Signature and title of certifier<br><b>[Signature] MO</b>  |  | 29c. License number<br><b>032654</b>  |  |
|   | 29d. Date signed (Month, Day, Year)<br><b>December 8, 1997</b>   |  |  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>John P. Serlemiotos 1509 Ritchie Highway, Arnold, MD 21012</b>   |  |   |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>DEC 12 1997</b>  |  |  |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |   |  |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 97 39504

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mildred L. Disbrow

2. Date of Death

Month Day Year  
Dec. 11, 1997

3. Time of Death

1:00 PM

4a. Facility Name (If not institution, give street and number)

320 Stockhams Lane

4b. City, Town, or Location of Death

Aberdeen

4c. County of Death

Harford

5. Social Security Number

186-10-7221

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
7/21/13

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

PA

10b. County

York

10c. City, Town or Location

Delta

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

410 Chestnut Street

10f. Zip Code

17314

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

John T. Butler

18. Mother's Name (First, Middle, Maiden Summa)

Lillie T. Watson

19a. Informant's Name/Relationship (Type, Print)

Victor J. Disbrow - son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

320 Stockhams Lane, Aberdeen, MD 21001

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Slate Ridge Cemetery 12/14/97 Delta, PA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Harkins F.H. Inc., Delta, PA 17314

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Liver carcinoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Asbestos

Due to (or as a consequence of):

c. Arterio sclerotic Cardiovascular

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

P20661

29d. Date signed (Month, Day, Year)

12/12/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. J.T. Lee, 669 Revolution Street, Havre de Grace, MD

31. Date filed (Month, Day, Year)

DEC 15 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 39505

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HELEN NUNA DAILEY

2. Date of Death

Dec 6 1997

3. Time of Death

2100

4a. Facility Name (If not Institution, give street and number)

WASHINGTON COUNTY HOSPITAL

4b. City, Town, or Location of Death

HAGERSTOWN

4c. County of Death

WASHINGTON

Funeral  
Director

5. Social Security Number

220-16-2900

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

MARCH 24, 1926

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WASHINGTON

10c. City, Town or Location

HAGERSTOWN

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

216 POTOMAC HEIGHTS

10f. Zip Code

21742

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 YEARS

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SECRETARY

16b. Kind of Business/Industry

STATE DEPARTMENT

17. Father's Name (First, Middle, Last)

JOHN T. KEPHART

18. Mother's Name (First, Middle, Maiden Surname)

BESSIE M. KEPHART

19a. Informant's Name/Relationship (Type, Print)

MARC F. DAILEY/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

216 POTOMAC HEIGHTS, HAGERSTOWN, MARYLAND 21742

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ROSE HILL CEMETERY 12/09/97

Date

20c. Location - City or Town, State

HAGERSTOWN, MARYLAND

21. Signature of Funeral Service Licensee

*P. Steven Danfelt, Jr.*

22. Name and Address of Facility

7606 Old National Pike  
BAST FUNERAL HOME Boonsboro, Maryland 21713

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

30 hrs

b. cerebrovascular infarction  
Due to (or as a consequence of):

30 hrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Cerebrovascular hemorrhage  
Due to (or as a consequence of):

30 hrs

d. Brain edema  
Due to (or as a consequence of):

24 hrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*P. Steven Danfelt, Jr.*

29c. License number

D20922

29d. Date signed (Month, Day, Year)

12/11/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

188 Thomas Johnson Jr Frederick md 21702.

31. Date filed (Month, Day, Year)

DEC 11 1997

32. Registrar's Signature

*Julia Davidson-Randall*State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39506

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Harry P. Edwards

2. Date of Death

Dec. 15 1997

3. Time of Death

9:30pm

4a. Facility Name (If not institution, give street and number)

116 Larue Square North

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

Funeral  
Director

5. Social Security Number

226-36-0541

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

(Month, Day, Year)

8-31-04

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Md.

10b. County

NONE

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

116 Larue Square North

10f. Zip Code

21225

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Farmer

16b. Kind of Business/Industry

Agriculture

17. Father's Name (First, Middle, Last)

Paul Edmunds

18. Mother's Name (First, Middle, Maiden Surname)

Mary Owens

19a. Informant's Name/Relationship (Type, Print)

Antionette Lacy (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

116 Larue Square  
Baltimore, Maryland 21225

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Bannister Hill Church

Cemetery

Date

12-20-97

20c. Location - City or Town, State

Halifax, VA.

21. Signature of Funeral Service Licensee

Hlander Coles

22. Name and Address of Facility

Tri-State Funeral Services, Inc.

6234 3rd. St. NW. Wash. DC. 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. *Gangrene @ Surg.*

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 wk.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *Cerebrovascular Accident*

Due to (or as a consequence of):

11 months

c. *Chronic Renal*

Due to (or as a consequence of):

1 yr.

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

C. J. Hill, MD

29c. License number

D14571

29d. Date signed (Month, Day, Year)

12/16/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

South Baltimore Family Health Center

631 Cherry Hill Road

Baltimore, Maryland 21225

31. Date filed (Month, Day, Year)

DEC 17 1997

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

John J. Smith

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 39507  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Clarence Edward Freeman

2. Date of Death

Month  
DECDay  
19Year  
1997

3. Time of Death

2:40 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

THE MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

EASTON

4c. County of Death

TALBOT

5. Social Security Number

214-32-0948

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

61 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 14, 1936

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Talbot

10c. City, Town or Location

Denton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8357-Harmony Road

10f. Zip Code

21629

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Security Officer

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

Frederick

Bartholemew

18. Mother's Name (First, Middle, Maiden Surname)

Mary Elizabeth Freeman

19a. Informant's Name/Relationship (Type, Print)

Georgianna Freeman

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8357 Harmony Road Denton, Maryland 21629

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Paradise Cemetery

Date

12/23/97 Trappe, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Janelle C. Henry

22. Name and Address of Facility

HENRY FUNERAL HOME  
510 Washington St. Cambridge, MD. 2161323a. Permit. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)e. Emphysema  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

10 yrs

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cardiomyopathy

malnutrition

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
8 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Janelle C. Henry

29c. License number

D44749

29d. Date signed (Month, Day, Year)

12/19/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter White Sell MD - 508 Idlewild Ave. Easton, MD. 21601

31. Date filed (Month, Day, Year)

DEC 22 1997

32. Registrar's Signature

John A. ...

State  
RegistrarCLARENCE FREEMAN  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39508

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BILLY JACK FOSTER

2. Date of Death

Month Day Year  
December 11, 1997

3. Time of Death

2:50 P.M.

4a. Facility Name (If not institution, give street and number)

6730 Hallowing Point Road

4b. City, Town, or Location of Death

Prince Frederick

4c. County of Death

Calvert

Funeral  
Director

5. Social Security Number

411-68-7792

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

55

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 1, 1942

9. Birthplace (State or Foreign Country)

TN

Usual Residence of Decedent

10a. State

MD

10b. County

Calvert

10c. City, Town or Location

Prince Frederick

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

6730 Hallowing Point Road

10f. Zip Code

20678

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give

Year or Dates:

1960

1964

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Mechanical Supervisor

16b. Kind of Business/Industry

Nuclear Power Plant

17. Father's Name (First, Middle, Last)

Elmer

Foster

18. Mother's Name (First, Middle, Maiden Surname)

Lavina

Shelton

19a. Informant's Name/Relationship (Type, Print)

Sandra Foster / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 412, Prince Frederick, MD 20678

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

MD Veterans Cemetery

Date

12/16/97

20c. Location - City or Town, State

Cheltenham, MD

21. Signature of Funeral Service Licensee

Charles F. Bell

22. Name and Address of Facility

Rausch Funeral Home

4405 Broomes Island RD, Port Republic, MD 20676

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Cholangiocarcinoma  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jonathan Lowenthal

29c. License number

033123

29d. Date signed (Month, Day, Year)

12.12.97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jonathan Lowenthal, M.D. Hospital Drive, Suite #200, Prince Frederick, MD 20678

31. Data filed (Month, Day, Year)

DEC 12 1997

32. Registrar's Signature

John Anderson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10+1  
gates



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 39509  
Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |  |  |   |  |
|---|---|--|---|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Irwin Fass</b>   |  |   |  | 2. Date of Death<br>Month <b>December</b> Day <b>10</b> Year <b>1997</b>   |  |  |  | 3. Time of Death<br><b>4:53 am</b>  |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>Suburban Hospital</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Bethesda</b>  |  |  |  | 4c. County of Death<br><b>Montgomery</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>579-50-8036</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.   |  | If Under 1 Year<br>Months Days   |  | If Under 24 Hrs.<br>Hours Min.  |  |
|   | 8. Date of Birth<br>(Month, Day, Year)<br><b>Jan. 26, 1916</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>New York, N.Y.</b>   |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b>   |  | 10c. City, Town or Location<br><b>Chevy Chase</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>3535 Chevy Chase Lake Dr. #203</b>   |  | 10f. Zip Code<br><b>20815</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>College (14 or 5+)</b>   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Air Force Office of Scientific Research</b>  |  | 16b. Kind of Business/Industry<br><b>U.S. Government</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Samuel Fass</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Leah Zaffe</b>  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Evelyn Fass/Wife</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3535 Chevy Chase Lake Dr. Chevy Chase, MD 20815</b>   |  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>                |  | 20c. Location - City or Town, State<br><b>Alexandria, VA</b>  |  |
| Physician<br>/Medical<br>Examiner             | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Ives-Pearson Funeral Homes</b><br><b>2847 Wilson Blvd. Arlington, VA 22201</b>   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>e. <b>Intracerebral Hemorrhage</b><br>Due to (or as a consequence of):<br>b. <b>Atrial Fibrillation</b><br>Due to (or as a consequence of):<br>c. <b>Cardiac Disease</b><br>Due to (or as a consequence of):<br>d. |  | Approximate Interval Between Onset and Death<br><b>16 hr.</b><br><b>years</b><br><b>years</b>                          |  |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. |  |   |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>   |  |
|   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| State Registrar                               | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D40353</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>12/10/97</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>James Yan, 11119 Rockville Pike #320 Rockville, MD 20852</b> |  |
|   | 31. Date filed (Month, Day, Year)<br><b>DEC 17 1997</b>   |  | 32. Registrar's Signature<br>   |  |  |  |  |  |   |  |

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39510

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last)

Robert Cameron Fisher

2. Date of Death

Month Day Year  
December 10, 1997

3. Time of Death

8:45 AM

4a. Facility Name (If not institution, give street and number)

3 Observation Court, # 3

4b. City, Town, or Location of Death

Germantown

4c. County of Death

Montgomery

5. Social Security Number

043-18-8230

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 1, 1918

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Germantown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3 Observation Court, # 3

10f. Zip Code

20876

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Minister

16b. Kind of Business/Industry

Theological

17. Father's Name (First, Middle, Last)

Robert George Fisher

18. Mother's Name (First, Middle, Maiden Surname)

Cordelia Ford

19a. Informant's Name/Relationship (Type, Print)

Elaine L. Fisher/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3 Observation Ct., # 3, Germantown, MD. 20876

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

12/10/97

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility DeVol Funeral Home

10 East Deer Park Dr., Gaithersburg, MD. 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

2 hours

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Coronary Artery Disease

Due to (or as a consequence of):

17 years

c. Three Vessel Bypass Surgery

Due to (or as a consequence of):

17 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Sonia M. Salmon M.D.

29c. License number

19419

29d. Date signed (Month, Day, Year)

12/10/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SONIA M. RHODEN-SALMON M.D.; 19701-03 EXECUTIVE PARK CIRCLE, GERMANTOWN MD 20874

31. Date filed (Month, Day, Year)

DEC 15 1997

32. Registrar's Signature

Julia Davidson-Randall

MD 20874

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

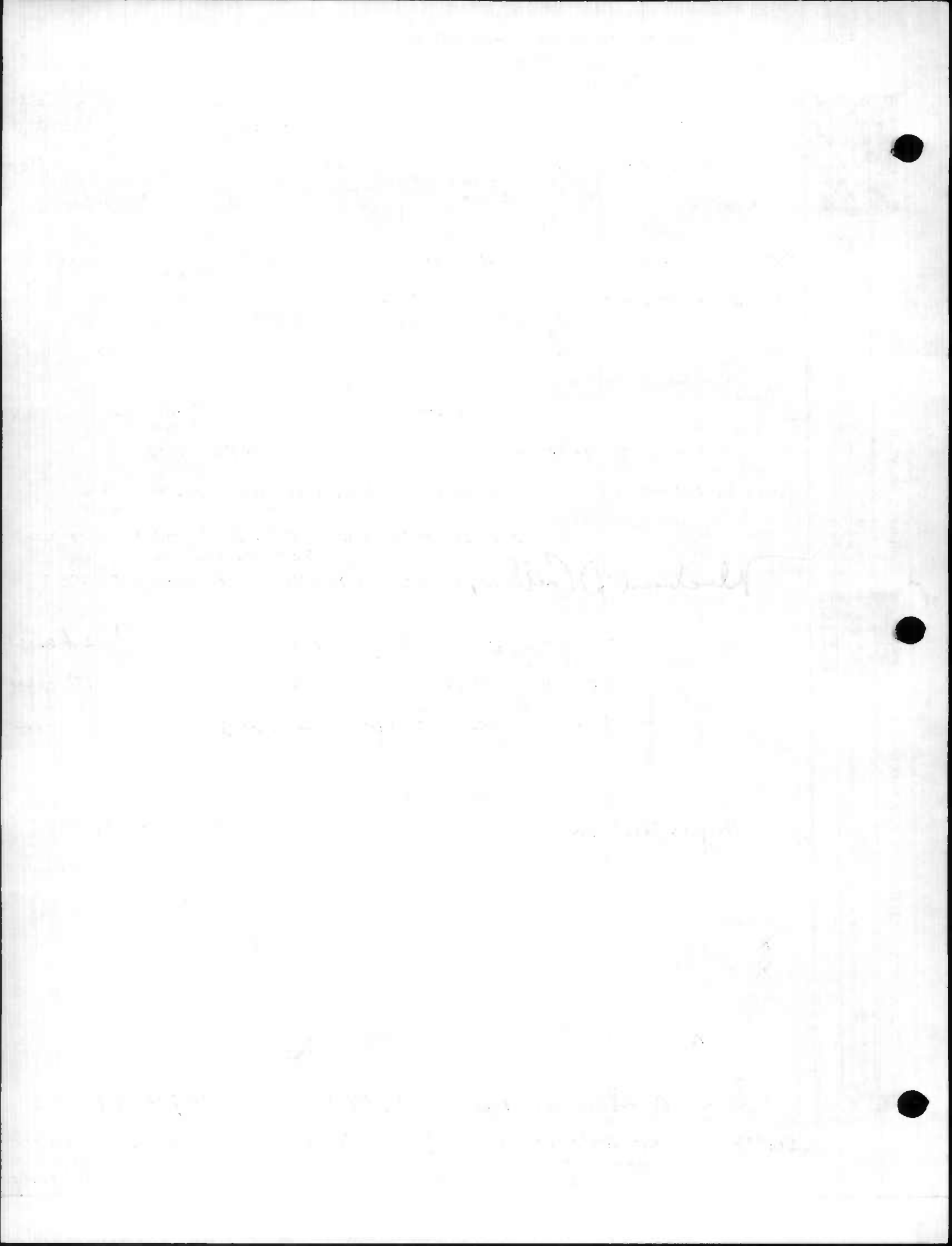
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 39511  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Josephine Clements Fitzgerald

2. Date of Death

Dec. 6, 1997

3. Time of Death

9:30 PM

4a. Facility Name (If not institution, give street and number)

Mariner Health of Kensington

4b. City, Town, or Location of Death

Kensington

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

579-44-9685

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

95

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Mar. 5, 1902

9. Birthplace (State or Foreign Country)

Wash., DC

Usual Residence of Decedent

10a. State

Md.

10b. County

Montgomery

10c. City, Town or Location

Kensington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

3000 McComas Avenue

10f. Zip Code

20895

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Navar Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Edmund A. Fitzgerald

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Fegan

19a. Informant's Name/Relationship (Type, Print)

Edmund A. Fitzgerald/nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6633 N. 32nd St., Arlington, Va. 22213

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

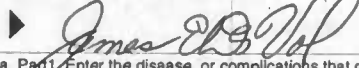
Mt. Olivet Cemetery Dec. 10, 97

Date

20c. Location - City or Town, State

Washington, DC

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

DeVol Funeral Home  
2222 Wisconsin Ave., N.W., Wash., DC 2000723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Cerebral Infarction

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

YEARS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MULTI-INFARCT DEMENTIA; SENILE IMBILITY;

GANGRENE RIGHT LOWER EXTREMITY

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M


28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D08944

29d. Date signed (Month, Day, Year)

12/8/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

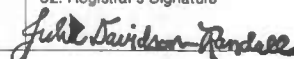
MARTIN C. SHARGEL, M.D.

3720 FALLAGUT AVE.  
KENSINGTON, MD - 20895State  
Registrar

31. Date filed (Month, Day, Year)

DEC 16 1997

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerDivision of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39512

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ethel Flanagan

2. Date of Death

DEC 11, 1997

3. Time of Death

6:15 PM

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

577-44-7304

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 8, 1933

9. Birthplace (State or Foreign Country)

Wash. DC

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13825 Castle Blvd., #12

10f. Zip Code

20904

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Dietician

16b. Kind of Business/Industry

Food Service

17. Father's Name (First, Middle, Last)

Joseph R. Armstrong

18. Mother's Name (First, Middle, Maiden Surname)

Ethel Greene

19a. Informant's Name/Relationship (Type, Print)

Laverne-Flanagan-Norman (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

31 Valley Park Ct., Damascus, MD 20872

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cem. 12/19/97 Silver Spring, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SNOWDEN FUNERAL HOME, P.A.  
ROCKVILLE, MD 20850

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiopulmonary Arrest

Due to (or as a consequence of):

b. Severe Cardiomyopathy

Due to (or as a consequence of):

c. Sepsis

Due to (or as a consequence of):

d. Renal Failure

months

days

weeks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 51714

29d. Date signed (Month, Day, Year)

12/12/1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jatinder Singh Sekhon

501 N. Frederick Ave., Gaithersburg, MD 20877

31. Date filed (Month, Day, Year)

DEC 17 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Bmw Ethel Flanagan 12-11-97 6:15 pm

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39513

|  |  |  |  |   |   |   |  |  |
|--|--|--|--|---|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><u>John L. Forston, Jr.</u>                      |  |  |   | 2. Date of Death<br>Month <u>Dec</u> Day <u>13</u> Year <u>1997</u> |   | 3. Time of Death<br><u>12:31 PM</u>                          |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><u>Holy Cross Hospital</u> |  |  |   | 4b. City, Town, or Location of Death<br><u>Silver Spring</u>        |   | 4c. County of Death<br><u>Montgomery</u>                     |  |
| Funeral<br>Director  | 5. Social Security Number<br><u>413-52-6794</u>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><u>59</u> Yrs.                    |   | 8. Date of Birth (Month, Day, Year)<br><u>April 15, 1938</u> |  |
|  | 9. Birthplace (State or Foreign Country)<br><u>Tennessee</u>                                 |  | 10a. State<br><u>Maryland</u>  |   | 10b. County<br><u>Montgomery</u>                                    |   | 10c. City, Town or Location<br><u>Silver Spring</u>          |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><u>1625H Carriage House Terrace</u>  |  | 10f. Zip Code<br><u>20904</u>   |   | 10g. Citizen of What Country?<br><u>United States</u>                                       |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>Black</u>                     |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>5+</u> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Electronic Engineer</u>  |  | 16b. Kind of Business/Industry<br><u>U.S. Government</u>  |   |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><u>John Lee Forston</u>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Sally Mae Jarvis</u>  |   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>David Anthony Forston, son</u>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>1625H Carriage House Terrace, Silver Spring, Md. 20904</u>                                |   |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Forest Hill Cemetery</u>  |  | 20c. Location - City or Town, State<br><u>Chattanooga, Tennessee</u>  |   | 20d. Date<br><u>12/21/97</u>  |  |  |
| 21. Signature of Funeral Service Licensee<br><u>[Signature]</u>  |  |  |  | 22. Name and Address of Facility<br><u>McGuire Funeral Service, Inc.</u><br><u>7400 Georgia Ave. N.W., Washington, D.C.</u>   |   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Cerebral vascular accident</u><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |  |   |   |   |  |  |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Hypertension</u>   |  |  |  |   |   |   |  |  |
| 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |  |  |   |   |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><u>M</u>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |   |   |  |  |
| 29b. Signature and title of certifier<br><u>[Signature]</u>  |  |  |  | 29c. License number<br><u>208546</u>  |   | 29d. Date signed (Month, Day, Year)<br><u>Dec 13 1997</u>                                   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>John Forston 8218 Wisconsin Ave Bethesda MD</u>   |  |  |  |   |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><u>DEC 19 1997</u>  |  | 32. Registrar's Signature<br><u>Julia Davidson-Randall</u>   |  |   |   |   |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39514

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dora Bachman

Friedman

2. Date of Death

Month Day Year  
December 17, 1997

3. Time of Death

2:27 PM

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

508-05-7727

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 28, 1920

9. Birthplace (State or Foreign Country)

Nebraska

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4708 OXBOW ROAD

10f. Zip Code

20852

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

HARRY BACHMAN

18. Mother's Name (First, Middle, Maiden Surname)

BELLE BATT

19a. Informant's Name/Relationship (Type, Print)

SUSAN FRIEDMAN (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

119 LAWDALE AVENUE, WILMETTE IL 60091

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

KING DAVID MEMORIAL GDNS 12/19/97 FALLS CHURCH VA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Danzansky-Goldberg Mem. Chapels, Inc.

1170 Rockville Pike, Rockville, MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebral Vascular Accident

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cholelithiasis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert H. Varney, MD

29c. License number

D20332 -

29d. Date signed (Month, Day, Year)

12/18/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert H. Varney, MD 9715 Medical Center Drive, Rockville, MD 20850

31. Date filed (Month, Day, Year)

DEC 19 1997

32. Registrar's Signature

Lila Davidson-Rodale

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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/Medical  
Examiner

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39515

|   |   |   |   |  |  |  |  |   |
|---|---|---|---|--|--|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Catherine E. Fowler</b>                                  |   |   |  | 2. Date of Death<br>Month <b>December</b> Day <b>13</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>0135 A</b>  |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>SHADY GROVE ADVENTIST HOSPITAL</b> |   |   |  | 4b. City, Town, or Location of Death<br><b>ROCKVILLE</b>   |  | 4c. County of Death<br><b>MONTGOMERY</b>   |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>234-01-7966</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>89</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>9/25/1908</b>  | 9. Birthplace (State or Foreign Country)<br><b>WV</b>   |
|   | Usual Residence of Decedent   |   |   |  |  |  |  |   |
| 10a. State<br><b>Md.</b>  |   | 10b. County<br><b>Montgomery</b>  |   | 10c. City, Town or Location<br><b>Gaithersburg</b>   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
| 10e. Street and Number<br><b>211 Russell Avenue Suite #421</b>  |   |   |   | 10f. Zip Code<br><b>20877</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                        |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b> College (1-4or 5+)  |   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>homemaker</b>                    |  |  | 16b. Kind of Business/Industry<br><b>own home</b>  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Adam L. Parkinson</b>   |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ann F. Stuckey</b>   |  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Jean Fulk</b>  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>808 Richard Street Martinsburg, WV 25401</b> |  |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Rosedale Cemetery</b>  |  | Date<br><b>12/16/97</b>  |  | 20c. Location - City or Town, State<br><b>Martinsburg, WV 25401</b>                            |   |
| 21. Signature of Funeral Service Licensee<br>   |   |   |   | 22. Name and Address of Facility<br><b>Rosedale Funeral Chapel, Inc.<br/>2060 Rosedale Rd., Mtsbg, WV 25401</b>                                  |  |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Cystic Hygroma</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |   |  |  |  |  | Approximate Interval Between Onset and Death<br><b>uncertain</b>  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Congestive heart failure</b>   |   |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |
|   |   |   |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   | 29b. Signature and title of certifier<br> MD   |   | 29c. License number<br><b>07231</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>December 13, 1997</b>  |  |   |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br><b>James R. Moore Jr. 207 Brookes Ave Gaithersburg MD 20877</b>   |   |   |   |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>DEC 15 1997</b>   |   | 32. Registrar's Signature<br>  |   |  |  |  |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar



There are a number of things that I want to mention to you.

First, I want to mention that I have been thinking about you a lot lately.

Second, I want to mention that I have been thinking about you a lot lately.

Third, I want to mention that I have been thinking about you a lot lately.

Fourth, I want to mention that I have been thinking about you a lot lately.

Fifth, I want to mention that I have been thinking about you a lot lately.

Sixth, I want to mention that I have been thinking about you a lot lately.

Seventh, I want to mention that I have been thinking about you a lot lately.

Eighth, I want to mention that I have been thinking about you a lot lately.

Ninth, I want to mention that I have been thinking about you a lot lately.

Tenth, I want to mention that I have been thinking about you a lot lately.

Eleventh, I want to mention that I have been thinking about you a lot lately.

Twelfth, I want to mention that I have been thinking about you a lot lately.

Thirteenth, I want to mention that I have been thinking about you a lot lately.

Fourteenth, I want to mention that I have been thinking about you a lot lately.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39516

|   |  |   |   |  |  |  |   |  |   |                  |                                  |   |                                   |                                    |
|---|--|---|---|--|--|--|---|--|---|------------------|----------------------------------|---|-----------------------------------|------------------------------------|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>DAVID ELMER FINKBY</b>  |   |   |  | 2. Date of Death<br>Month <b>DECEMBER</b> Day <b>16</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>20:22</b>  |  |   |                  |                                  |   |                                   |                                    |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>WASHINGTON COUNTY HOSPITAL</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>HAGERSTOWN</b>  |  | 4c. County of Death<br><b>WASHINGTON</b>                                |  |   |                  |                                  |   |                                   |                                    |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-09-4030A</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 4 1914</b>               | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>                                |   |                  |                                  |   |                                   |                                    |
|   | Usual Residence of Decedent  |   |   |  |  |  |   |  |   |                  |                                  |   |                                   |                                    |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Washington</b>  |  | 10c. City, Town or Location<br><b>Hagerstown</b>   |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |                  |                                  |   |                                   |                                    |
|   | 10e. Street and Number<br><b>621 Medway Road</b>   |   |   |  | 10f. Zip Code<br><b>21740</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |  |   |                  |                                  |   |                                   |                                    |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |   |                  |                                  |   |                                   |                                    |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> Collage (1-4 or 5+) <b>0</b>   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Supervisor</b>   |  | 16b. Kind of Business/Industry<br><b>Sandblasting</b>                   |  |   |                  |                                  |   |                                   |                                    |
|   | 17. Father's Name (First, Middle, Last)<br><b>David Elmer Finkey</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Susan Numaker</b>  |  |   |  |   |                  |                                  |   |                                   |                                    |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Hilda Finkey</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>621 Medway Road Hagerstown, Maryland 21740</b>   |  |   |  |   |                  |                                  |   |                                   |                                    |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Rest Haven Cemetery</b>  |  | Data<br><b>12/20/97</b>  |  | 20c. Location - City or Town, State<br><b>Hagerstown, Maryland</b>      |  |   |                  |                                  |   |                                   |                                    |
|   | 21. Signature of Funeral Service Licensee<br><i>Scott Minnich</i>  |   |   |  | 22. Name and Address of Facility<br><b>Minnich Funeral Home<br/>415 E. Wilson Blvd. Hagerstown, Md. 21740</b>  |  |   |  |   |                  |                                  |   |                                   |                                    |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |  |  |  |   |  |   |                  |                                  |   |                                   |                                    |
|   | <table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>SEPSIS</b></td> <td rowspan="4">Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death<br/><b>4 days</b></td> </tr> <tr> <td>b. <b>URINARY TRACT INFECTION</b></td> </tr> <tr> <td>c. <b>CEREBROVASCULAR ACCIDENT</b></td> </tr> <tr> <td>d. </td> </tr> </table> |   |   |  |  |  |   |  | Immediate Cause (Final disease or condition resulting in death) | a. <b>SEPSIS</b> | Due to (or as a consequence of): | Approximate Interval Between Onset and Death<br><b>4 days</b> | b. <b>URINARY TRACT INFECTION</b> | c. <b>CEREBROVASCULAR ACCIDENT</b> |
| Immediate Cause (Final disease or condition resulting in death)   | a. <b>SEPSIS</b>   | Due to (or as a consequence of):  | Approximate Interval Between Onset and Death<br><b>4 days</b>   |  |  |  |   |  |   |                  |                                  |   |                                   |                                    |
|   | b. <b>URINARY TRACT INFECTION</b>  |   |   |  |  |  |   |  |   |                  |                                  |   |                                   |                                    |
|   | c. <b>CEREBROVASCULAR ACCIDENT</b>   |   |   |  |  |  |   |  |   |                  |                                  |   |                                   |                                    |
|   | d.   |   |   |  |  |  |   |  |   |                  |                                  |   |                                   |                                    |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>PERIPHERAL VASCULAR DISEASE</b><br><b>HISTORY OF SMOKING</b><br><b>GOUT</b>  |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |   |                  |                                  |   |                                   |                                    |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |  |  |   |  |   |                  |                                  |   |                                   |                                    |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |   |  |   |                  |                                  |   |                                   |                                    |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28e. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>                  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   | 28d. Describe how injury occurred  |   |                  |                                  |   |                                   |                                    |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><i>[Signature]</i> MD  |   | 29c. License number<br><b>040622</b>             |  | 29d. Date signed (Month, Day, Year)<br><b>DECEMBER 16, 1997</b>  |   |  |   |                  |                                  |   |                                   |                                    |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ERNST LUTZ KAVIN MD. 19236 MARYLAND DR HAGERSTOWN MD.</b>  |  |   |   |  |  |  |   |  |   |                  |                                  |   |                                   |                                    |
| 31. Date filed (Month, Day, Year)<br><b>DEC 18 1997</b>   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |  |  |   |  |   |                  |                                  |   |                                   |                                    |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97-39517

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Albert Fields

2. Date of Death  
Month Day Year

December 10 1997

3. Time of Death

2:06 AM

4a. Facility Name (If not institution, give street and number)

6902 Emerson St.

4b. City, Town, or Location of Death

Hyattsville

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

251-46-0734

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

63

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 6, 1934

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10e. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6902 Emerson St.

10f. Zip Code

20784

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16e. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Correctional Supervisor

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Joe Fields

18. Mother's Name (First, Middle, Maiden Surname)

Suepearl Bates

19a. Informant's Name/Relationship (Type, Print)

Erma B. Fields / Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6902 Emerson St., Hyattsville, MD 20784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Ft. Lincoln Cemetery

Date

12/13/97

20c. Location - City or Town, State

Brentwood, MD

21. Signature of Funeral Service Licensee

John T. Stewart, III

22. Name and Address of Facility

Stewart Funeral Home

4001 Benning Rd., N.E. Wash., D.C. 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

a. METASTATIC LUNG CARCINOMA

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

9 MONTHS

Immediate Cause (Final  
disease or condition  
resulting in death)Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last.

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending  
Investigation 6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
injury28c. Injury et  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Nickolas Pungam

29c. License number

D23308

29d. Date signed (Month, Day, Year)

DECEMBER 10, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

VICTOR M. PRIEGO, M.D. 6410 ROCKLEDGE DRIVE # 625 BETTESDA, MD 20817

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 15 1997

32. Registrar's Signature

John T. Stewart, III

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 39518

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Thelma F. Frazier

2. Date of Death

Month

Day

Year

December 14, 1997 2:55 PM

3. Time of Death

Funeral  
Director

4e. Facility Name (If not institution, give street and number)

Mariner Health of Kensington

4b. City, Town, or Location of Death

Kensington

4c. County of Death

Montgomery

5. Social Security Number

579-22-7404

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Jan. 20, 1908

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

Washington, D.C.

10e. Street and Number

729 Nicholson Street, N.W.

10f. Zip Code

20011

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housekeeper

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

Pleasant Flood

18. Mother's Name (First, Middle, Maiden Surname)

Martha Johnson

19a. Informant's Name/Relationship (Type, Print)

James E. Randall-Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6330 Garlock Way, Colorado Springs, Colorado 80918

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

12-18-97 Brentwood, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

James E. Johnson

22. Name and Address of Facility

Fort Lincoln Funeral Home

3401 Bladensburg Rd., Brentwood, Maryland 20722

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Multiple Myeloma

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Myron L. Lenkin, M.D.

29c. License number

D06674

29d. Date signed (Month, Day, Year)

December 18, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Myron L. Lenkin, M.D. 2309 Shorefield Road, Wheaton, Maryland 20902

31. Date filed (Month, Day, Year)

DEC 18 1997

32. Registrar's Signature

James E. Johnson

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39519

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Eva

Gouge

2. Date of Death

Month  
December

Day

10

Year

1997

3. Time of Death

1:35 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Mariner Health of Forest Hill

4b. City, Town, or Location of Death

Forest Hill

4c. County of Death

Harford

5. Social Security Number

218-32-6551

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Aug. 20 1907

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Forest Hill

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

410 McPhale Dr.

10f. Zip Code

21014

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

5

18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

Riley McKinney

18. Mother's Name (First, Middle, Maiden Surname)

Jane Buchannan

19a. Informant's Name/Relationship (Type, Print)

Helen Morena (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

702 Ponderosa Dr. Bel Air MD 21014

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Calvary Baptist Cemetery

Date

12/13/97

20c. Location - City or Town, State

Ridgeville MD

21. Signature of Funeral Service Licensee

Harry W. Haight

22. Name and Address of Facility

Haight Funeral Home

P.O. Box 195 Sykesville MD 21784

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Cerebrovascular accident

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

old age

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Shirley MD

29c. License number

D 32609

29d. Date signed (Month, Day, Year)

12/10/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kammodin Micham MD 703 Revolution St - Harre De Gran MD 21078

31. Date filed (Month, Day, Year)

DEC 15 1997

32. Registrar's Signature

Phyllis Anderson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

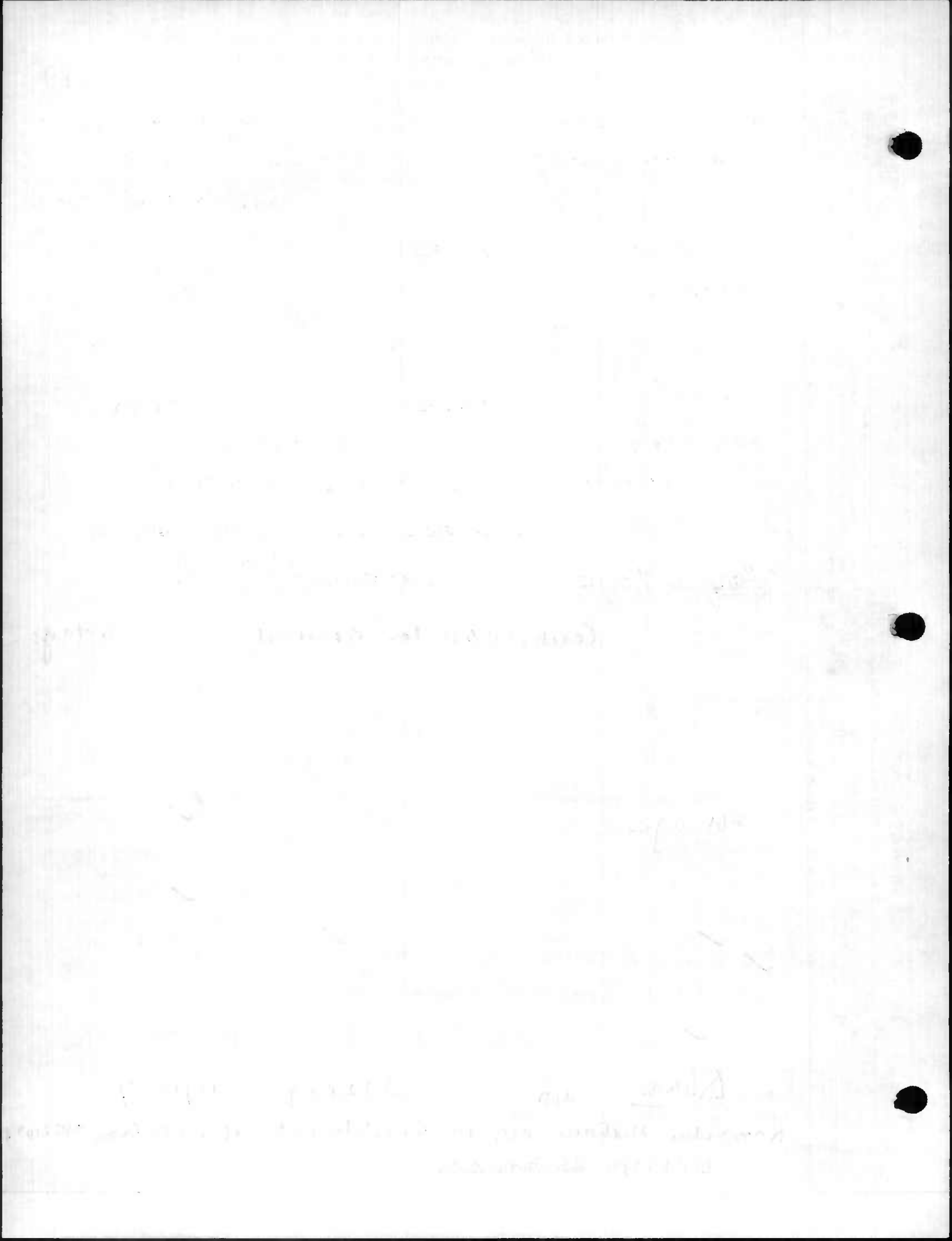
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 39520**  
Certificate of Death

Reg. No.

|   |   |   |   |                                      |  |  |   |                                   |  |
|---|---|---|---|--------------------------------------|--|--|---|-----------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Marian Estelle Gateau</b>  |   |   |                                      | 2. Date of Death<br>Month Day Year<br><b>DEC 14 1997</b>   |  | 3. Time of Death<br><b>2:53 A:M</b>                                     |                                   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>PHYSICIANS MEMORIAL HOSPITAL</b>   |   |   |                                      | 4b. City, Town, or Location of Death<br><b>LAPLATA</b>   |  | 4c. County of Death<br><b>CHARLES</b>                                   |                                   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>577-07-8923</b>   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |                                      | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Sept 16 1913</b>              |                                   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Wash. DC</b>   |   | 10a. State<br><b>MD</b>   |                                      | 10b. County<br><b>St. Mary's</b>   |  | 10c. City, Town or Location<br><b>Hollywood</b>                         |                                   |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |   |   |                                      | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |                                   |  |
|   | 10e. Street and Number<br><b>24762 Half Pone Pt. Rd.</b>  |   |   |                                      | 10f. Zip Code<br><b>20636</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |                                   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |                                   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> Collage (1-4or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                         |                                      | 16b. Kind of Business/Industry<br><b>Home</b>  |  |   |                                   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Harry Joseph Higgs</b>  |   |   |                                      | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Mary Elizabeth Eastburn Higgs</b>  |  |   |                                   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Amiel J. Gateau/Husband</b>  |   |   |                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>24762 Half Pone Pt. Rd. Hollywood, MD 20636</b>  |  |   |                                   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)             |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cem.</b>  |                                      | Date<br><b>12/18/97</b>  |  | 20c. Location - City or Town, State<br><b>Suitland, MD</b>              |                                   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>David C. Enoch</i>  |   | 22. Name and Address of Facility<br><b>AREHART-ECHOLS FUNERAL HOME, PA</b>  |                                      | P.O. Box 567 LaPlata, MD 20646   |  |   |                                   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Arteriosclerotic Cardiovascular Disease</b> |   | Due to (or as a consequence of):  |                                      | Approximate Interval Between Onset and Death<br><b>Years</b>   |  |   |                                   |  |
|   | Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>Arteriosclerotic Cardiovascular Disease</b>  |   | Due to (or as a consequence of):  |                                      |  |  |   |                                   |  |
| Due to (or as a consequence of):  |   |   |   |                                      |  |  |   |                                   |  |
| Due to (or as a consequence of):  |   |   |   |                                      |  |  |   |                                   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.  |   |   |   |                                      |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |   |                                   |  |
|   |   |   |   |                                      |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |                                   |  |
|   |   |   |   |                                      |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |                                   |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |   |                                      |  |  |   |                                   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>      |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 28d. Describe how injury occurred |  |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |                                      |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |                                   |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><i>Amiel J. Gateau</i>   |   | 29c. License number<br><b>027380</b> |  | 29d. Date signed (Month, Day, Year)<br><b>12/18/97</b>   |   |                                   |  |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br><b>Howard Haft, MD 700 Old Line Center Suite 100 Waldorf, MD 20602</b>  |   |   |   |                                      |  |  |   |                                   |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 17 1997</b>   |   | 32. Registrar's Signature<br><i>Johi Shuler-Randall</i>   |   |                                      |  |  |   |                                   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39521

|   |   |  |   |  |  |  |  |  |
|---|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Louise Elizabeth Gallagher  |  |   |  | 2. Date of Death<br>Dec 7 1997 Year  |  | 3. Time of Death<br>11 am  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>890 Solomons Island Road  |  |   |  | 4b. City, Town, or Location of Death<br>Prince Frederick   |  | 4c. County of Death<br>Calvert   |  |
| Funeral<br>Director   | 5. Social Security Number<br>578 22 4464  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (in yrs. last birthday)<br>73 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>April 11 1924                                 |  |
|   | 9. Birthplace (State or Foreign Country)<br>Maryland  |  | 10a. State<br>Maryland  |  | 10b. County<br>Calvert   |  | 10c. City, Town or Location<br>Prince Frederick                                      |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br>890 Solomons Island Road  |  | 10f. Zip Code<br>20678   |  | 10g. Citizen of What Country?<br>United States                                       |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Navar Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: white                     |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>8   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>school bus aide                          |  | 16b. Kind of Business/Industry<br>P.G. County Gov.   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>George Washington Fagan  |  |   |  | 18. Mother's Name (First, Middle, Maiden Sumame)<br>Beulah M. Amonette   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Sherrie L. Polen- daughter  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>P.O. Box 219 Benedict Maryland 20612  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Southern Memorial Gardens   |  | 20c. Location - City or Town, State<br>Dunkirk Cal. Maryland   |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>B Rausch   |  |   |  | 22. Name and Address of Facility<br>Rausch Funeral Home<br>4405 Broomes Is. Rd. Port Republic MD 20676   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>a. Coronary Artery Disease<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):                              |  |   |  |  |  |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |  |  |  |  |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |   |  |  |  |  |  |
| Physician<br>/Medical<br>Examiner   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Paroxysmal Atrial fibrillation  |  |   |  |  |  |  |  |
|   | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |  |  |  |  |
|   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |   |  |  |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|   | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |  |  |  |  |
|   | 29b. Signature and title of certifier<br>Varkey Mathew, M.D.  |  |   |  | 29c. License number<br>D45435  |  | 29d. Date signed (Month, Day, Year)<br>12/8/97                                       |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Varkey Mathew, M.D. 110 Hospital Rd. Suite 301 Prince Frederick MD 20678  |  |   |  |  |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br>DEC 12 1997  |  |   |  | 32. Registrar's Signature<br>John Davidson Randall   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended #18, 12/22/97, JW, Mont. Co, per F H **Certificate of Death**

Reg. No.

97 39522

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edith B. Gregory

2. Date of Death

Month Day Year  
December 11, 1997

3. Time of Death

7:00 am

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

219-64-3589

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
February 6, 1910

9. Birthplace (State or Foreign Country)

Arkansas

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Kensington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4203 Ambler Drive

10f. Zip Code

20895

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Lee Hickam

18. Mother's Name (First, Middle, Maiden Surname)

Margot Birdsong Burchett

19a. Informant's Name/Relationship (Type, Print)

Barbara G. Keate/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

315 Bayview Avenue Rehoboth Beach, Delaware 19971

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rock Creek Cemetery

Date

December 15, 1997

20c. Location - City or Town, State

Washington, D.C.

21. Signature of Funeral Service Licensee

*[Signature]*

M00335

22. Name and Address of Facility

Robert A. Humphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular accident

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 days

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Brent A. Berger MD*

29c. License number

D37840

29d. Date signed (Month, Day, Year)

December 11, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brent A. Berger, M.D. 11125 Rockville Pike, Rockville, Maryland 20852

31. Date filed (Month, Day, Year)

DEC 17 1997

32. Registrar's Signature

*Julia Davidson-Randall*

State  
Registrar

02  
7 AM  
December 11, 1997  
Edith Gregory  
Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39523

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edward V. Garabedian

2. Date of Death

Month Day Year  
December 12, 1997

3. Time of Death

3:06 PM

4a. Facility Name (If not institution, give street and number)

20925 Sunny Acres Road

4b. City, Town, or Location of Death

Laytonsville

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

579-34-5993

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

April 10, 1929 New York

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Laytonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

20925 Sunny Acres Road

10f. Zip Code

20882

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Financial Administrator

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Vahan Garabedian

18. Mother's Name (First, Middle, Maiden Surname)

Virginia Shamlian

19a. Informant's Name/Relationship (Type, Print)

Vahan R. Garabedian (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

444 Gainsborough Court, Severna Park, MD 21146

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parklawn Memorial Park 12/15/97 Rockville, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Eric S. Scerbo

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ESOPHAGEAL CARCINOMA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

ONE YEAR

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joseph Kaplan MD

29c. License number

D 35635

29d. Date signed (Month, Day, Year)

December 14, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOSEPH KAPLAN 18111 Prince Philip Dr. OLNEY, MD 20832

31. Date filed (Month, Day, Year)

DEC 15 1997

32. Registrar's Signature

John Davidson-Rodell

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene 97 39524

Certificate of Death

Reg. No.

|  |  |   |  |  |  |  |  |  |
|--|--|---|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>IRENE C. GEORGATSOS</b>                       |   |  |  | 2. Date of Death<br>Month Day Year<br><b>Dec 11, 1997</b>    |  | 3. Time of Death<br><b>06:05pm</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>HOLY CROSS HOSPITAL</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>SILVER SPRING</b> |  | 4c. County of Death<br><b>MONTGOMERY</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>579-48-6187</b>  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>89</b> Yrs.   | If Under 1 Year<br>Months Days                               | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>DEC. 24, 1907</b>  | 9. Birthplace (State or Foreign Country)<br><b>LYNN, MA</b>      |
|  | Usual Residence of Decedent  |   |  |  |  |  |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>MONTGOMERY</b>  |  | 10c. City, Town or Location<br><b>KENSINGTON</b>   |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>3620 LITTLEDALE DRIVE</b>   |  |   |  | 10f. Zip Code<br><b>20895</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                            |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SALES ASSOCIATE</b>  |  |  | 16b. Kind of Business/Industry<br><b>HECHT COMPANY</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>PETER ALAFOGINIS</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>DIMITRA PAPADOPOULOS</b>   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>NICHOLAS GEORGATSOS SON</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11321 MARCLIFF ROAD, NORTH BETHESDA, MD 20852</b>  |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CEDAR HILL CEMETERY</b>   |  | Date<br><b>12/15/97</b>  |  | 20c. Location - City or Town, State<br><b>SUITLAND, MARYLAND</b> |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>JOSEPH GAWLER'S SONS, INC. 5130 WI AVENUE, N.W. WASHINGTON, D.C. 20016</b>  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>ARRHYTHMIA</b><br>Due to (or as a consequence of):<br><b>SICK SINUS SYNDROME</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>24 HOURS</b><br><br>e. Due to (or as a consequence of):<br>f. Due to (or as a consequence of):<br>g. Due to (or as a consequence of):<br>h. Due to (or as a consequence of): |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>24 HOURS</b>  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |
|  |  |   |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |
|  |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred                                |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D 50300</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>Dec 12, 1997</b>   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Thomas J Anthony MD 11119 Rookville Pk Rockville md 20852</b>   |  |   |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 15 1997</b>  |  | 32. Registrar's Signature<br>  |  |  |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

37 39525

|  |   |  |   |   |  |   |  |  |
|--|---|--|---|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Charles Edward Goings, Jr.  |  |   |   | 2. Date of Death<br>Month Day Year<br>December 12, 1997  |   | 3. Time of Death<br>4:10 AM                                      |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>9709 Meadowcroft Lane   |  |   |   | 4b. City, Town, or Location of Death<br>Gaithersburg   |   | 4c. County of Death<br>Montgomery                                |  |
| Funeral<br>Director  | 5. Social Security Number<br>579-07-5864  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>Yrs. 76  |   | 8. Date of Birth (Month, Day, Year)<br>April 24, 1921            |  |
|  | 9. Birthplace (State or Foreign Country)<br>Virginia  |  | 10a. State<br>Maryland  |   | 10b. County<br>Montgomery  |   | 10c. City, Town or Location<br>Gaithersburg                      |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent   |  |   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |  |
|  | 10e. Street and Number<br>9709 Meadowcroft Lane   |  |   |   | 10f. Zip Code<br>20879   |   | 10g. Citizen of What Country?<br>U.S.A.                          |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1944-1974 |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>4   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Military Officer                                   |   | 16b. Kind of Business/Industry<br>Federal Government   |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Charles Edward Goings  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Gladys Louise Rose  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Margaret F. Goings (wife)   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>9709 Meadowcroft Lane, Gaithersburg, Maryland 20879   |   |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Arlington National Cemetery   |   | 20c. Location - City or Town, State<br>Arlington, Virginia   |   | 20d. Date<br>12/18/97  |  |
|  | 21. Signature of Funeral Service Licensee<br>William L. Boyd  |  |   |   | 22. Name and Address of Facility<br>Francis J. Collins Funeral Home, Inc.<br>500 University Blvd., W., Silver Spring, MD 20901   |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Congestive Heart Failure<br>Due to (or as a consequence of):<br>Stroke<br>Due to (or as a consequence of):<br>Renal Failure<br>Due to (or as a consequence of): |  |   |   | Approximate Interval Between Onset and Death<br>Several months<br>Several months<br>Several months   |   |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                           |  |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA   |   | 26. Place of Death (Check only one)<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   | 29b. Signature and title of certifier<br>Philip J. Schwartz MD  |  | 29c. License number<br>D24398   |  |  |
| 29d. Date signed (Month, Day, Year)<br>DECEMBER 12 1997  |   | 29e. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Philip Schwartz MD 15225 SHADY GROVE ROAD ROOM 302 ROCKVILLE MARYLAND 20850 |   | 29f. Date filed (Month, Day, Year)<br>DEC 15 1997   |  | 32. Registrar's Signature<br>John Davidson-Randall  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene 97 39526

## Certificate of Death

Reg. No.

|  |  |   |   |   |   |  |  |  |
|--|--|---|---|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Delma Goldstein  |   |   |   | 2. Date of Death<br>Month Day Year<br>December 12, 1997 |  | 3. Time of Death<br>10:30 PM   |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br>Manor Care Health Services Chevy Chase |   |   |   | 4b. City, Town, or Location of Death<br>Chevy Chase     |  | 4c. County of Death<br>Montgomery  |  |
| Funeral<br>Director  | 5. Social Security Number<br>339-01-5484   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>82 Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                          | 8. Date of Birth (Month, Day, Year)<br>May 17, 1915                                  |  | 9. Birthplace (State or Foreign Country)<br>New York   |
|  | Usual Residence of Decedent  |   |   |   |   |  |  |  |
| 10a. State<br>Maryland   |  | 10b. County<br>Montgomery   |   | 10c. City, Town or Location<br>Chevy Chase  |   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 10e. Street and Number<br>4450 South Park Avenue, #713   |  |   |   | 10f. Zip Code<br>20815  |   | 10g. Citizen of What Country?<br>United States                                       |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4  |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Social Worker  |   |  | 16b. Kind of Business/Industry<br>State of New Jersey  |  |
| 17. Father's Name (First, Middle, Last)<br>Jacob Finkelstein   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Zena Broder  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Michael Goldstein (son)  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4450 South Park Avenue, #713, Chevy Chase, MD 20815  |   |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Mount Ararat Cemetery   |   | Date<br>12-16-97  |   | 20c. Location - City or Town, State<br>East Farmingdale, New York                    |  |  |
| 21. Signature of Funeral Service Licensee<br>Carol A. Delma  |  |   |   | 22. Name and Address of Facility<br>Rapp Funeral Services, P.A.<br>933 Gist Avenue, Silver Spring, Maryland 20910   |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Cancer of Pancreas<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |   |   |  |  | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |   |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br>Raj Mathur   |   | 29c. License number<br>D 42403  |   | 29d. Date signed (Month, Day, Year)<br>December 13, 1997                             |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Raj Mathur, M.D., 106 Irving Street, NW, #202, Washington, D.C. 20017  |  |   |   |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>DEC 15 1997   |  | 32. Registrar's Signature<br>Julia Davidson-Randall   |   |   |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39527

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Willadean V. Gregory

2. Date of Death

Dec 15 97

Day Year

3. Time of Death

6:15 pm

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

235-32-0247

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 9, 1922

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Jessup

10d. Inside City Limits

XX Yes 2 ☐ No

10e. Street and Number

8042 Andiron Lane

10f. Zip Code

20794

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Owner/Operator

16b. Kind of Business/Industry

Grocery store

17. Father's Name (First, Middle, Last)

Hammond

Spielman

18. Mother's Name (First, Middle, Maiden Surname)

Rachel Ardella Elizabeth McCoy

19a. Informant's Name/Relationship (Type, Print)

Herbert J. Gregory, Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8042 Andiron Lane, Jessup, MD 20794

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenway Cemetery

Date

Dec. 17, 1997

20c. Location - City or Town, State

Berkeley Springs, WV

21. Signature of Funeral Service Licensee

M00522

22. Name and Address of Facility

Helsley-Johnson Funeral Home, Inc.

306 Union St., Berkeley Springs, WV 25411

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Endstage lung cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to Immediate Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jacob Cherman MD

29c. License number

D50973

29d. Date signed (Month, Day, Year)

Dec 15, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JACOB CHERMAN

Patient Medical Group

Two Knoll North Dr. Columbia MD 21045

31. Date filed (Month, Day, Year)

DEC 19 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

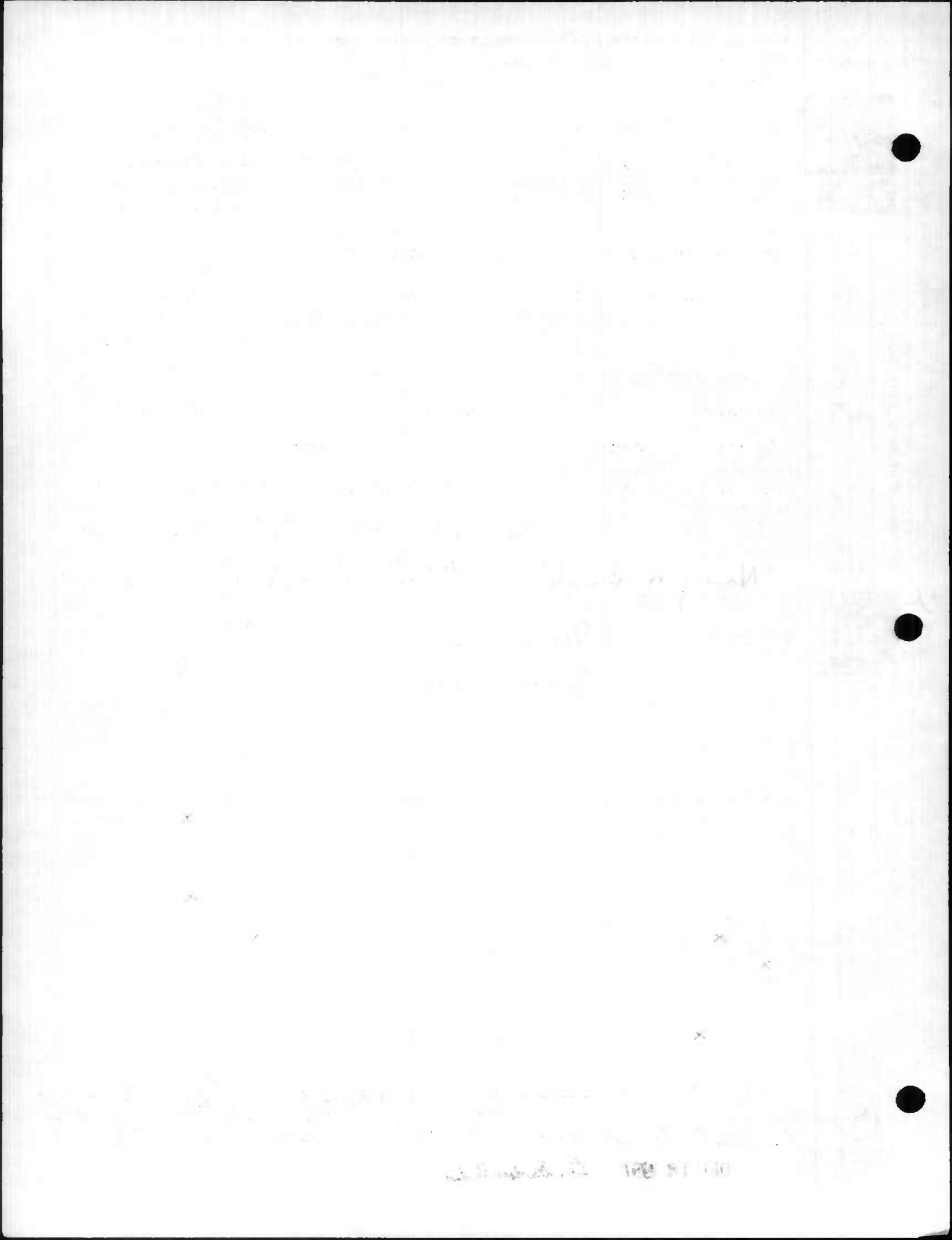
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39528

|   |   |  |   |                               |  |  |   |   |  |   |  |
|---|---|--|---|-------------------------------|--|--|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>BERNARD THEODORE GREENE   |  |   |                               |  | 2. Date of Death<br>Month Day Year<br>December 11 1997   |   | 3. Time of Death<br>8:30 PM   |  |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>9024 South Cherry Lane  |  |   |                               |  | 4b. City, Town, or Location of Death<br>Upper Marlboro   |   | 4c. County of Death<br>Prince George's  |  |   |  |
| Funeral<br>Director   | 5. Social Security Number<br>579-14-9967  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |                               | 7. Age (In yrs. last birthday)<br>77 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>01-19-1920 |   | 9. Birthplace (State or Foreign Country)<br>Maryland |   |  |
|   | Usual Residence of Decedent   |  |   |                               |  |  |   |   |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland  |  | 10b. County<br>Prince George's  |                               | 10c. City, Town or Location<br>Upper Marlboro  |  |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |
|   | 10e. Street and Number<br>9024 South Cherry Lane  |  |   |                               | 10f. Zip Code<br>20772   |  |   | 10g. Citizen of What Country?<br>U.S.A.   |  |   |  |
|   | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                               | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: Black  |  |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>Unknown   |  |   |                               | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Laborer   |  |   | 16b. Kind of Business/Industry<br>Government  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br>William A. Greene  |  |   |                               |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Henrietta Hall  |   |   |  |   |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>Paul A. Greene/Brother  |  |   |                               |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>9024 S. Cherry Lane, Upper Marlboro, MD 20772 |   |   |  |   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Resurrection Cemetery   |                               |  | 20c. Location - City or Town, State<br>Clinton, Maryland   |   | 20d. Date<br>12/16 1997   |  |   |  |
|   | 21. Signature of Funeral Service Licensee<br>Nancy A. Pasanti   |  |   |                               |  | 22. Name and Address of Facility<br>J. B. JENKINS FUNERAL HOME<br>7474 Landover Road, Landover, Maryland 20785                                 |   |   |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>e. Renal failure<br>Due to (or as a consequence of):<br>b. Prostate Cancer<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d. |  |   |                               |  |  |   |   |  |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |                               |  |  |   |   |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   |                               |  |  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |   |                               |  |  |   |   |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   |                               |  |  |   |   |  |   |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |   |  |   |                               |  |  |   |   |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)                          |   | 28b. Time of Injury<br>M      |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 28d. Describe how injury occurred   |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br>Robert M. Chiaramonte |   | 29c. License number<br>D37043 |  | 29d. Date signed (Month, Day, Year)<br>Dec 12, 1997  |   | 29e. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Robert M. Chiaramonte, M.D. 7501 SURREATHS RD #308 CLINTON, MD 20745 |  |   |  |
| 31. Date filed (Month, Day, Year)<br>DEC 16 1997  |   | 32. Registrar's Signature<br>[Signature]                       |   |                               |  |  |   |   |  |   |  |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39529

|  |   |  |   |   |  |
|--|---|--|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>ESTHER MELBA GRIM</b>  |  | 2. Date of Death<br>Month <b>DECEMBER</b> Day <b>4</b> Year <b>1997</b>   |   | 3. Time of Death<br><b>10:20 PM</b>  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>7985 CROWNSWAY</b>   |  | 4b. City, Town, or Location of Death<br><b>GLEN BURNIE</b>  |   | 4c. County of Death<br><b>ANNE ARUNDEL</b>   |
| Funeral<br>Director  | 5. Social Security Number<br><b>213-30-9936</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>64</b> Yrs.  | If Under 1 Year<br>Months Days                        | If Under 24 Hrs.<br>Hours Min.   |
|  | 8. Date of Birth (Month, Day, Year)<br><b>AUG. 12, 1933</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |   |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent   |  |   |   |  |
|  | 10e. State<br><b>MARYLAND</b>   | 10b. County<br><b>ANNE ARUNDEL</b>   | 10c. City, Town or Location<br><b>GLEN BURNIE</b>   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|  | 10e. Street and Number<br><b>7985 CROWNSWAY</b>   |  | 10f. Zip Code<br><b>21061</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>N/A</b>   |   |  |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>   |  | 16b. Kind of Business/Industry<br><b>OWN HOME</b>   |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>BERNARD H. THUMAN, SR.</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>HELENA SCHIMMEL</b>   |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>GERIANNE H. HEBB (DAUGHTER)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>474 WORTHINGTON ROAD, MILLERSVILLE, MD. 21108</b>   |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MARYLAND VETERANS CEMETERY</b>   |   | 20c. Location - City or Town, State<br><b>CROWNSVILLE, MD.</b>   |
|  | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>SINGLETON FUNERAL HOME, P.A.<br/>1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</b>   |   |  |
| Physician<br>/Medical<br>Examiner  | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Metastatic breast cancer</b><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequitentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   | Approximate Interval Between Onset and Death<br><b>14 years</b>  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |
|  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |   |  |
| 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>D16587</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>12/5/97</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Paul Chang, MD 5601 Loch Raven Blvd., Baltimore, MD 21239</b>   |   |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 11 1997</b>  |   | 32. Registrar's Signature<br>  |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39530

|  |   |  |   |   |   |  |  |  |  |  |
|--|---|--|---|---|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>SARAH GREEN   |  |   |   | 2. Date of Death<br>Month Day Year<br>DEC. 9 1997   |  |  |  | 3. Time of Death<br>1752   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>ANNE ARUNDEL MEDICAL CENTER   |  |   |   | 4b. City, Town, or Location of Death<br>ANNAPOLIS   |  |  |  | 4c. County of Death<br>ANNE ARUNDEL  |  |
| Funeral<br>Director  | 5. Social Security Number<br>213-22-1725  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>Yrs. 73   |  | 8. Date of Birth (Month, Day, Year)<br>JULY 1 1924     |  | 9. Birthplace (State or Foreign Country)<br>MARYLAND   |  |
|  | Usual Residence of Decedent   |  |   |   |   |  |  |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>MARYLAND  |  | 10b. County<br>ANNE ARUNDEL   |   | 10c. City, Town or Location<br>ANNAPOLIS  |  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|  | 10e. Street and Number<br>1120 MADISON STREET APT. A3   |  |   |   | 10f. Zip Code<br>21403  |  | 10g. Citizen of What Country?<br>US                    |  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: BLACK |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11th College (1-4 or 5+) 0   |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>DOMESTIC   |  |  | 18b. Kind of Business/Industry<br>OUT SIDE THE HOME              |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>JOSHUA WATKINS   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>MAMIE WESTON   |  |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>ROSEMARY BUTLER (DAUGHTER)  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>126 CONLEY DRIVE ANNAPOLIS, MD. 21403  |  |  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>EBENEZER CHURCH CEMETERY  |   | Date<br>12/15/97  |  | 20c. Location - City or Town, State<br>GALESVILLE, MD. |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Larry S. Reese</i>  |  |   |   | 22. Name and Address of Facility<br>WM. REESE & SONS MORTUARY, P.A.<br>821 WEST ST. ANNAPOLIS, MD. 21401  |  |  |  |  |  |
|  | 23e. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                       |  |   |   |   |  |  |  |  |  |
|  | Physician<br>/Medical<br>Examiner   | Immediate Cause (Final disease or condition resulting in death)<br>a. Myocardial Infarction<br>Due to (or as a consequence of):<br>b. Coronary Artery Disease<br>Due to (or as a consequence of):<br>c. Atherosclerosis<br>Due to (or as a consequence of):<br>d. Hypertension |   |   |   |  |  | Approximate Interval Between Onset and Death<br>1 hr<br>1 yr.    |  |  |
| Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |   |  |   |   |   |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>End Stage Renal Disease<br>Dialysis  |   |  |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |  |
|  |   |  |   |   |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |  |
|  |   |  |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |   | 28. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> QOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br>M  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred                                |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |  |  |
| 29e. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |   |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br><i>Dennis M. Hall MD</i>  |   |  |   | 29c. License number<br>D41216   |   | 29d. Date signed (Month, Day, Year)<br>12-11-97  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dennis M. Hall, M.D. 1204 W. St. Annapolis MD  |   |  |   |   |   |  |  |  |  |  |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)<br>DEC 12 1997  |  |   |   | 32. Registrar's Signature<br><i>Johia Davidson-Pendell</i>  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39531

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY

E.

GERARD

2. Date of Death

Month

Day

Year

December 8, 1997

3. Time of Death

3:35 PM

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

302-26-6870

6. Sex

☐ M☒ F

7. Age (In yrs. last birthday)

66

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

June 5, 1931

9. Birthplace (State or Foreign Country)

Columbus, OH

Usual Residence of Decedent

10a. State

Ohio

10b. County

Madison

10c. City, Town or Location

London

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

149 North Main Street

10f. Zip Code

43140

10g. Citizen of What Country?

United States of America

11. Marital Status

☐ Navar Married☒ Married☐ Widowed☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Charles John Bangham

18. Mother's Name (First, Middle, Maiden Surname)

Marguerite Sines

19a. Informant's Name/Relationship (Type, Print)

Richard C. Gerard

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

149 North Main St. London, Ohio 43140

20a. Method of Disposition

☐ Burial☒ Cremation☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Jerry Spears Crematory

Date

12-13-97

20c. Location - City or Town, State

Columbus, Ohio

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Eberle Funeral Home

103 N. Main St. London, Ohio 43140

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Intracerebral haemorrhage  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cerebrovascular accident  
Due to (or as a consequence of):

1-2 days

c. Respiratory failure  
Due to (or as a consequence of):

1

d. Accelerated hypertension

1-2 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

History of congestive heart failure

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

1

Inpatient

2

ER/Outpatient

3

DOA

26. Place of Death (Check only one)

Other:

4

Nursing Home

5

Residence

6

Other (Specify)

27. Manner of Death

☒ Natural☐ Pending investigation☐ Accident☐ Could not be determined☐ Suicide☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D24174

29d. Date signed (Month, Day, Year)

12/8/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PADMAJA UDAPA 7350 VanDusen Road Laurel MD 20707

31. Date filed (Month, Day, Year)

DEC 12 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



97 39532

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Solomon Shea Goldstein</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>December 3, 1997</b>  |  | 3. TIME OF DEATH<br><b>2:05 AM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>579-16-0546</b>  |  | 5. SEX<br><b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>96</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>April 11, 1901</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Russia</b>  |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Laurelwood Care Center</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Elkton</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Cecil</b>  |  |   |  | 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Cecil</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Elkton</b>   |  |   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>100 Laurel Drive</b>   |  |
| 10f. ZIP CODE<br><b>21921</b>  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br><b>3</b> <input checked="" type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:  |  |   |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>10</b> Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b>   |  |   |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Pianist/Tuner</b>  |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Music</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Samuel (NMN) Goldstein</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Rebecca (NMN) Scornic</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Robert Goode/ Nephew</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2515 Deer Valley Way, Bel Air, Maryland 21015</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>St. Barnabus Cemetery 12-6-97</b>  |  |   |  |
| 20c. LOCATION — City or Town, State<br><b>Temple Hills, Maryland</b>   |  |   |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Charles A. Emge</i>  |  |   |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>Howard K. McComas III Funeral Home, P. A.<br/>1317 Cokesbury Road, Abingdon, Maryland</b>   |  |   |  | 23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. <b>Sepsis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Aspiration</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>Senile Dementia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>Approximate Interval Between Onset and Death<br><b>3 days</b><br><b>3 months</b><br><b>5 years</b> |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO  |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO  |  |   |  | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA<br>OTHER: <b>4</b> <input checked="" type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)   |  |   |  |
| 27. MANNER OF DEATH<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending investigation<br><b>2</b> <input type="checkbox"/> Accident<br><b>3</b> <input type="checkbox"/> Suicide <b>6</b> <input type="checkbox"/> Could not be determined<br><b>4</b> <input type="checkbox"/> Homicide   |  |   |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>28b. TIME OF INJURY</b> <b>M</b><br><b>28c. INJURY AT WORK?</b> <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO<br><b>28d. DESCRIBE HOW INJURY OCCURRED</b><br><b>28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)</b><br><b>28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)</b>  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Monte Makous, MD</b>   |  |   |  |
| 29c. LICENSE NUMBER<br><b>D-44783</b>  |  |   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>December 3, 1997</b>   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MONTA MAKOUS, MD 111 WEST HIGH STREET, ELKTON, MD 21921</b>  |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 5 1997</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Charles Herdall</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39533

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LILLIAN Antoinette GIESEMAN

2. Date of Death  
Month Day Year

DECEMBER 10, 1997 12:5pm

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

ER FALLSTON GENERAL HOSPITAL FALLSTON

4b. City, Town, or Location of Death

HARFORD

5. Social Security Number

220-05-3819

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year  
Months Days

If Under 24 Hrs.  
Hours Min.

8. Date of Birth  
(Month, Day, Year)

May 15, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Joppa

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

590 Renee Drive

10f. Zip Code

21085

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

18b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Raymond (U/K)

Pfeiffer

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth (U/K)

Carnucci

19a. Informant's Name/Relationship (Type, Print)

Diana McMullen /Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2900 Felicity Ct., Jarrettsville, Maryland 21084

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Highview Memorial Gardens 12-13-97 Fallston, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Howard K. McComas III Funeral Home, P.A.

1317 Cokesbury Road, Abingdon, Maryland 21009

23a. Part 7. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE CORONARY ARTERY DISEASE

Due to (or as a consequence of):

b. A S W D

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending Investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

NA

28b. Time of Injury

NA

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

NA

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

NA

28f. Location (Street and Number or Rural Route Number, City or Town, State)

NA

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*[Signature]* ONE

29c. License number

D21809

29d. Date signed (Month, Day, Year)

DEC 10 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G. PRABHU 218 FALLSTON DRIVE BELAIR MD 21014 8746564

31. Date filed (Month, Day, Year)

DEC 16 1997

32. Registrar's Signature

*[Signature]*

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

LILLIAN GIESEMAN

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 39534

|   |   |  |   |   |  |   |   |  |  |  |  |  |
|---|---|--|---|---|--|---|---|--|--|--|--|--|
| <b>Physician<br/>/Medical<br/>Examiner</b>                                  | 1. Decedent's Name (First, Middle, Last)<br>Yvonne Faye Hawkins   |  |   |   |  | 2. Date of Death<br>Month Day Year<br>December 11, 1997   |   |  | 3. Time of Death<br>2:00 p.m.  |  |  |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br>853 Regent Street   |  |   |   |  | 4b. City, Town, or Location of Death<br>Westminster   |   |  | 4c. County of Death<br>Carroll   |  |  |  |
| <b>Funeral<br/>Director</b>   | 5. Social Security Number<br>215-42-6374  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>53 Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br>Oct. 14, 1944  |  | 9. Birthplace (State or Foreign Country)<br>PA   |  |  |  |
|   | Usual Residence of Decedent   |  |   |   |  |   |   |  |  |  |  |  |
| <b>To Be Completed by Funeral Director</b>                                  | 10a. State<br>MD  |  | 10b. County<br>Carroll  |   | 10c. City, Town or Location<br>Westminster   |   |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |  |
|   | 10e. Street and Number<br>853 Regent Street   |  |   |   |  | 10f. Zip Code<br>21157  |   | 10g. Citizen of What Country?<br>United States                   |  |  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Bus driver |  |   | 16b. Kind of Business/Industry<br>School  |  |  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Charles Luther Frank   |  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary Virginia DuVall   |   |  |  |  |  |  |
| <b>To Be Completed by Physician/Medical Examiner</b>                        | 19a. Informant's Name/Relationship (Type, Print)<br>T. Earl Hawkins/husband   |  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>853 Regent St. Westminster, MD 21157 |   |  |  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Lakeview Mem. Gard. 12/15/97                  |  |   | 20c. Location - City or Town, State<br>Eldersburg, MD   |  |  |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  |   |   |  | 22. Name and Address of Facility<br>91 Willis Street<br>Myers Funeral Home Westminster, MD 21157                                      |   |  |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Idiopathic Pulmonary Fibrosis</u><br>Due to (or as a consequence of):<br><br>b. _____<br>Due to (or as a consequence of):<br><br>c. _____<br>Due to (or as a consequence of):<br><br>d. _____<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |   |   |  |  |  | Approximate Interval Between Onset and Death<br>Yrs  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.<br><u>Obesity</u>  |  |   |   |  |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| <b>Medical Certification: To Be Completed by Physician/Medical Examiner</b> | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |   |   |  |  |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |  |  |
|   |   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                       |  |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |   |  |   |   |  |  |  |  |  |
|   | 29b. Signature and title of certifier<br> MD   |  | 29c. License number<br>D33681   |   | 29d. Date signed (Month, Day, Year)<br>12/12/97  |   |   |  |  |  |  |  |
| <b>State Registrar</b>  | 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br>M.K. McEvoy, 7590 COLLEGE AVE SYKESVILLE MD 21784   |  |   |   |  |   |   |  |  |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br>DEC 12 1997  |  |   |   |  | 32. Registrar's Signature<br>                      |   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39535

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ELIJAH

HUNTER

2. Date of Death  
Month Day Year

DECEMBER 11, 1997

3. Time of Death

01:15

4a. Facility Name (If not institution, give street and number)

Calvert Memorial Hospital

4b. City, Town, or Location of Death

Prince Frederick

4c. County of Death

Calvert

5. Social Security Number

212-14-5008

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 31, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Calvert

10c. City, Town or Location

Prince Frederick

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

315 Crescent Court Apt. 107

10f. Zip Code

20678

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No 1942-  
If Yes, Give Year or Dates: 1943

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Collega (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Grocery Store

17. Father's Name (First, Middle, Last)

Roy

Hunter

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude

Butler

19a. Informant's Name/Relationship (Type, Print)

Mary Estelle Hunter/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

315 Crescent Ct. Apt. 107 Prince Frederick, MD 20678

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans' Cem.

Date

12/17/97

20c. Location - City or Town, State

Cheltenham, MD

21. Signature of Funeral Service Licensee

Spencer E. Sewell

22. Name and Address of Facility

Sewell Funeral Home

1451 Dares Beach Rd. Prince Frederick, MD 20678

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac arrhythmic

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last

b. Cor Pulmonale

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD

CHF

Chronic Renal insufficiency

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☐ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Varkey Mathew

29c. License number

045435

29d. Date signed (Month, Day, Year)

12/11/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Varkey Mathew, M.D. Prince Frederick, Maryland 20678

31. Date filed (Month, Day, Year)

DEC 16 1997

32. Registrar's Signature

Julia Annick-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39536

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John C. Hammett

2. Date of Death

Month

Day

Year

December

15

1997

3. Time of Death

1636

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

578-20-9660

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

October 8, 1925

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9701 Fields Road, Apt. 301

10f. Zip Code

20878

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: 1943-

1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Budget Analyst

16b. Kind of Business/Industry

Food & Drug  
Administration

17. Father's Name (First, Middle, Last)

Norman Wetherall Hammett

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Myers

19a. Informant's Name/Relationship (Type, Print)

Dolores B. Hammett

(wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9701 Fields Road, Apt. 301, Gaithersburg, MD 20878

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Chesapeake Crematory

Date

12-16-97

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

E. De L. Villalva

22. Name and Address of Facility

Rapp Funeral Services, P.A.

933 Gist Avenue, Silver Spring, MD 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1 hour

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Medical Examiner2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William Dooley, MD

29c. License number

033261

29d. Date signed (Month, Day, Year)

December 15, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

William Dooley, MD, 9901 Medical Center Drive, Rockville, MD 20850

31. Date filed (Month, Day, Year)

DEC 18 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 39537  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Miriam K. Hardesty

2. Date of Death

Month Day Year  
December 14 1997 9:25 AM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not Institution, give street and number)

Manor Care Health Services

4b. City, Town, or Location of Death

Silver Spring Montgomery

4c. County of Death

Montgomery

5. Social Security Number

579-28-9029

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 2, 1906

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10e. State

Maryland Prince Georges

10b. County

10c. City, Town or Location

Beltsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4903 Brandon Lane

10f. Zip Code

20705

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

United States Government

17. Father's Name (First, Middle, Last)

John C. Herlocher

18. Mother's Name (First, Middle, Maiden Surname)

Gertie May Johnson

19a. Intendant's Name/Relationship (Type, Print)

Dottie L. Miller Personal Representative

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4905 Brandon Lane Beltsville Maryland 20705

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Cemetery 12-15-97 Alexandria Virginia

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Matthew A Brown

22. Name and Address of Facility

Borgwardt Funeral Home  
4400 Powder Mill Rd Beltsville MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

b. Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 weeks

one month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Matthew A Brown

29c. License number

D37975

29d. Date signed (Month, Day, Year)

December 15 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

/Jeffrey P. Indrisano, M.D. 10801 Lockwood Drive; Suite 280, Silver Spring, MD 20901

31. Date filed (Month, Day, Year)

DEC 18 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

10. The first of these is the  
fact that the number of  
cases of the disease is

8. The second is the fact  
that the number of cases  
is not proportional to the  
number of people in the  
community.

The third is the fact that  
the number of cases is not  
proportional to the number of  
people in the community.  
The fourth is the fact that  
the number of cases is not  
proportional to the number of  
people in the community.

The fifth is the fact that  
the number of cases is not  
proportional to the number of  
people in the community.  
The sixth is the fact that  
the number of cases is not  
proportional to the number of  
people in the community.

The seventh is the fact that  
the number of cases is not  
proportional to the number of  
people in the community.  
The eighth is the fact that  
the number of cases is not  
proportional to the number of  
people in the community.

The ninth is the fact that  
the number of cases is not  
proportional to the number of  
people in the community.  
The tenth is the fact that  
the number of cases is not  
proportional to the number of  
people in the community.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39538

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Bernardine O'Donnell Harley

2. Date of Death  
Month Day Year  
December 13, 1997

3. Time of Death

12:25 AM

4a. Facility Name (If not institution, give street and number)

Carriage Hill of Bethesda

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

578-66-8243

8. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

95

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Aug. 2, 1902

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10e. State

N/A

10b. County

N/A

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

20008 Quebec Street, N.W.

10f. Zip Code

20006

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Managerial

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

John B. O'Donnell

18. Mother's Name (First, Middle, Maiden Surname)

Nora Carroll

19e. Informant's Name/Relationship (Type, Print)

Daniel P. O'Donnell (brother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3115 Fairland Road Silver Spring, Maryland 20904

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

12/17/97 Silver Spring, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

1 week

b. Stroke

Due to (or as a consequence of):

3 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D04179

29d. Date signed (Month, Day, Year)

12/15/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James J. Foster, M.D. 5530 Wisconsin Avenue #925 Chevy Chase, Maryland 20815

31. Date filed (Month, Day, Year)

DEC 17 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39539

Physician  
/Medical  
Examiner

Funeral  
Director

|   |  |   |  |  |  |  |  |   |  |                              |  |
|---|--|---|--|--|--|--|--|---|--|------------------------------|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Henry J. Haurand</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>December 11, 1997</b>   |  |  |  | 3. Time of Death<br><b>7:45 AM</b>  |  |                              |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Manor Care - Chevy Chase</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Chevy Chase</b>   |  |  |  | 4c. County of Death<br><b>Montgomery</b>  |  |                              |  |
| 5. Social Security Number<br><b>223-03-9324</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>August 30, 1915</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>   |  |                              |  |
| Usual Residence of Decedent   |  |   |  |  |  |  |  |   |  |                              |  |
| 10a. State<br><b>VA</b>   |  | 10b. County<br><b>Chesterfield</b>  |  | 10c. City, Town or Location<br><b>Bon Air</b>  |  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                              |  |
| 10e. Street and Number<br><b>8616 Choctaw Road</b>  |  |   |  | 10f. Zip Code<br><b>23235</b>  |  |  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |                              |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |                              |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Chemical Specialist</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>Dupont</b>   |  |                              |  |
| 17. Father's Name (First, Middle, Last)<br><b>Henry A. Haurand</b>  |  |   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Louise Shutz</b>   |  |   |  |                              |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Henry Haurand, Jr. (son)</b>   |  |   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9205 East Parkhill Drive, Bethesda, MD 20814</b> |  |   |  |                              |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Greenwood Memorial Cemetery</b>   |  |  |  | 20c. Location - City or Town, State<br><b>Richmond, VA</b>  |  | 20d. Date<br><b>12/13/97</b> |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901</b>   |  |  |  |   |  |                              |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. congestive heart failure</b><br>Due to (or as a consequence of):<br><b>b. acute myocardial infarction</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>1 week or days</b> |  |   |  |  |  |  |  |   |  |                              |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |  |  |  |  |  | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                              |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |  |  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |                              |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  |  |  | 28a. Date of Injury (Month, Day, Year)  |  |                              |  |
| 28b. Time of Injury<br><b>M</b>   |  |   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 28d. Describe how Injury occurred   |  |                              |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |                              |  |
| 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br><b>D08546</b>   |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>December 14, 1997</b>   |  |                              |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>John Tauber 8218 Wisconsin Avenue, Bethesda, MD 20814</b>  |  |   |  |  |  |  |  |   |  |                              |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 16 1997</b>   |  |   |  | 32. Registrar's Signature<br>   |  |  |  |   |  |                              |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39540

|   |   |   |   |  |   |  |  |  |
|---|---|---|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>CELESTINE P. HEBRON</b>  |   |   |  | 2. Date of Death<br>Month <b>Dec</b> Day <b>10</b> , Year <b>1997</b>   |  | 3. Time of Death<br><b>8:35 Pm</b>   |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>Fairland Nursing Home</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>  |  | 4c. County of Death<br><b>Montgomery</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-60-7269</b>   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>May 21, 1913</b>   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |
|   | Usual Residence of Decedent   |   |   |  |   |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>   |   | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Rockville</b>   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|   | 10e. Street and Number<br><b>11 Wood Lane</b>   |   |   |  | 10f. Zip Code<br><b>20850</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                            |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11th</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Printers Assistant</b>  |  | 16b. Kind of Business/Industry<br><b>Printing</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner   | 17. Father's Name (First, Middle, Last)<br><b>Darius Prather</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sarah Copelin</b>   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Laverne Jackson (Sister)</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8601 Warfield Rd., Gaithersburg, MD 20882</b>   |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parklawn Mem. Park</b>   |  | Date<br><b>12/16/97</b>   |  | 20c. Location - City or Town, State<br><b>Rockville, MD</b>  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |   | 22. Name and Address of Facility<br><b>SNOWDEN FUNERAL HOME, P.A.<br/>ROCKVILLE, MD 20850</b>   |  |   |  |  |  |
| Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Anterior Septal MI</b><br>Due to (or as a consequence of):<br><b>b. Disease</b><br>Due to (or as a consequence of):<br><b>c. Disease</b><br>Due to (or as a consequence of):<br><b>d. Disease</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |   |   |  |   |  |  | Approximate interval Between Onset and Death   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
|   | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 28. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicida 4 <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day Year)                       |   | 28b. Time of Injury<br><b>M</b>                  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><i>[Signature]</i> |   | 29c. License number<br><b>208546</b>             |   | 29d. Date signed (Month, Day, Year)<br><b>Dec 16 1997</b>                            |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>John N. Tauber 8218 Wisconsin Ave Bethesda</b>   |   |   |   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 17 1997</b>   |   | 32. Registrar's Signature<br><i>[Signature]</i>             |   |  |   |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 39541**  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Evelyn M. Hite

2. Date of Death

Month Day Year  
December 12, 1997

3. Time of Death

2:00 PM

4a. Facility Name (If not institution, give street and number)

6048 Avon Drive

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

577-36-1069

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 11, 1916

9. Birthplace (State or Foreign Country)

Montana

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

6048 Avon Drive

10f. Zip Code

20814

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Owner

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Joseph McDonald

18. Mother's Name (First, Middle, Maiden Surname)

Agnes

(not available)

19a. Informant's Name/Relationship (Type, Print)

Timothy T. Hite / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8126 Old Georgetown Rd., Bethesda, Maryland 20814

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Parklawn Memorial Park

Date

Dec. 16, 1997

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

 M0034822. Name and Address of Facility Robert A. Pumphrey Funeral Home/  
Bethesda-Chevy Chase, Inc., 7557 Wisconsin Ave.  
Bethesda, Maryland 20814-350123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Multiple Myeloma

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

5 years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

28. Place of Death (Check only one)

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
Investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide

28e. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

 MO

29c. License number

D21531

29d. Date signed (Month, Day, Year)

December 16, 1997

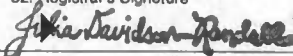
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

G. Peter Pushkas, M.D., 11510 Old Georgetown Road, Rockville, Maryland 20852

31. Date filed (Month, Day, Year)

DEC 17 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39542

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James W. Hobbs

2. Date of Death

Month

Day

Year

December 11, 1997

3. Time of Death

7:35 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

260-03-5420

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
June 17, 1922

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Kensington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3204 Ferndale Street

10f. Zip Code

20895

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Navar Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Chief of Operations

HUD

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Walter Hobbs

18. Mother's Name (First, Middle, Maiden Surname)

Lucille Stripling

19a. Informant's Name/Relationship (Type, Print)

Geraldine W. Hobbs (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3204 Ferndale Street Kensington, Maryland 20895

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metropolitan Crematory 12/13/97 Alexandria, Virginia

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

William L. Byrd

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

e. Hyperkalemia

10 Hrs.

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Respiratory Insufficiency

19 Years

Due to (or as a consequence of):

c. Peripheral Vascular Occlusive Disease

19 Years

Due to (or as a consequence of):

d. Diabetes Insulin Dependent

15 Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James M. Salander, M.D.

29c. License number

D39064

29d. Date signed (Month, Day, Year)

December 12, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James M. Salander, M.D. 11119 Rockville Pike #204 Rockville, Maryland 20852

31. Date filed (Month, Day, Year)

DEC 15 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitJames Hobbs Dec. 11, 1997 1935-  
Division of Vital Records, P.O. Box 68760,

10+



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 39543**  
**Certificate of Death**

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) **Betty Carolyn Hynes** 2. Date of Death Month **December** Day **15**, Year **1997** 3. Time of Death **9:00 AM**

Funeral  
Director

4a. Facility Name (If not institution, give street and number) **Holy Cross Hospital** 4b. City, Town, or Location of Death **Silver Spring** 4c. County of Death **Montgomery**

5. Social Security Number **578-40-0899** 6. Sex ☐ M ☒ F 7. Age (In yrs. last birthday) **76** Yrs. If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) **Dec. 29, 1920** 9. Birthplace (State or Foreign Country) **Pennsylvania**

Usual Residence of Decedent 10a. State **Maryland** 10b. County **Montgomery** 10c. City, Town or Location **Wheaton** 10d. Inside City Limits ☐ Yes ☒ No

10e. Street and Number **3514 Farthing Drive** 10f. Zip Code **20906** 10g. Citizen of What Country? **USA**

11. Marital Status ☐ Never Married ☒ Married ☐ Widowed ☐ Divorced 12. Was Decedent Ever In U.S. Armed Forces? ☒ Yes ☐ No If Yes, Give Year or Dates: **WW II** 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: **White**

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) **12** College (1-4or 5+) **2** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Registered Nurse** 16b. Kind of Business/Industry **Health Care**

17. Father's Name (First, Middle, Last) **Eric Paulsen** 18. Mother's Name (First, Middle, Maiden Surname) **Anna Martz**

19a. Informant's Name/Relationship (Type, Print) **Robert E. Hynes / Son** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **5215 Muncaster Mill Road, Rockville, Maryland 20855**

20a. Method of Disposition ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) **Fort Lincoln Crematory** Date **12/17/97** 20c. Location - City or Town, State **Brentwood, Maryland**

21. Signature of Funeral Service Licensee **[Signature]** 22. Name and Address of Facility **Hines-Rinaldi Funeral Home**  
**11800 New Hampshire Avenue**  
**Silver Spring, Maryland 20904**

23a. Part I. Enter the disease, or diseases, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **VENTRICULAR FIBRILLATION** **TERM.**

**CORONARY ATHEROSCLEROSIS** **YRS.**

**ARTERIOSCLEROTIC, HYPERTENSIVE C.V.D.** **YRS.**

23b. Did tobacco use contribute to the cause of death? ☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☒ No

25. Was case referred to medical examiner? ☒ Yes ☐ No 26. Place of Death (Check only one) Hospital: ☐ Inpatient ☐ ER/Outpatient ☒ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury **M** 28c. Injury at Work? ☐ Yes ☒ No 28d. Describe how Injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier **Donald R. Lewis MD** 29c. License number **D06406** 29d. Date signed (Month, Day, Year) **DECEMBER 16, 1997**

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) **DONALD R. LEWIS MD** **4000 RT108 OLNEY, MD 20832**

31. Date filed (Month, Day, Year) **DEC 18 1997** 32. Registrar's Signature **[Signature]**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

*[Handwritten signature]*

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 39544**  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elinor Halle

2. Date of Death  
Month Day Year  
December 14, 1997

3. Time of Death  
12:30 PM

4a. Facility Name (If not institution, give street and number)

4948 Sentinel Drive, Apt. 206

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

007-09-6926

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 3, 1915

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10e. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4948 Sentinel Drive, Apt. 206

10f. Zip Code

20816

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Foreign Service Officer

16b. Kind of Business/Industry

United States Information Agency

17. Father's Name (First, Middle, Last)

Jerome N. Halle

18. Mother's Name (First, Middle, Maiden Surname)

Madeline Solomon

19a. Informant's Name/Relationship (Type, Print)

Robert L. Bamberger (nephew)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3187 Key Boulevard, Arlington, Virginia 22201-5041

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

12-15-97

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

*Carol A. [Signature]*

22. Name and Address of Facility

Rapp Funeral Services, P.A.  
933 Gist Avenue, Silver Spring, Maryland 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Congestive Heart Failure

Approximate Interval Between Onset and Death

15 months

a. Due to (or as a consequence of):

Hypertension

Years

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atherosclerosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

D35456

29d. Date signed (Month, Day, Year)

December 15, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lila T. McConnell, M.D., 2 Wisconsin Circle, Chevy Chase, Maryland 20815

31. Date filed (Month, Day, Year)

DEC 15 1997

32. Registrar's Signature

*[Signature]*

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39545

|   |   |   |  |                                      |  |   |   |  |  |
|---|---|---|--|--------------------------------------|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>JAMES R. HOWE SR.</b>  |   |  |                                      | 2. Date of Death<br>Month Day Year<br><b>DECEMBER 5 1997</b>   |   | 3. Time of Death<br><b>05:15 AM</b>                                     |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>NORTH ARUNDEL HOSPITAL</b>   |   |  |                                      | 4b. City, Town, or Location of Death<br><b>GLEN BURIE</b>  |   | 4c. County of Death<br><b>ANNE ARUNDEL</b>                              |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-16-7372</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |                                      | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>SEPT. 27 1919</b>             |  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |   | 10a. State<br><b>MARYLAND</b>  |                                      | 10b. County<br><b>ANNE ARUNDEL</b>   |   | 10c. City, Town or Location<br><b>ANNAPOLIS</b>                         |  |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |   |  |                                      | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |  |  |
|   | 10e. Street and Number<br><b>63 SPA ROAD</b>  |   |  |                                      | 10f. Zip Code<br><b>21401</b>  |   | 10g. Citizen of What Country?<br><b>US</b>                              |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1941-45</b> |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b> |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9th</b> College (1-4 or 5+) <b>0</b>  |   |  |                                      | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CUSTODIAN</b>  |   | 16b. Kind of Business/Industry<br><b>US NAVAL ACADEMY</b>               |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>GEORGE HOWE</b>   |   |  |                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARTHA ISSAC</b>   |   |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>JAMES R. HOWE, JR. (SON)</b>   |   |  |                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>63 SPA ROAD ANNAPOLIS, MD. 21401</b>   |   |   |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MARYLAND VETERAN CEMETERY</b>   |                                      | Date<br><b>12/10/97</b>  |   | 20c. Location - City or Town, State<br><b>CROWNSVILLE, MD.</b>          |  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Larry J. Reese</i>  |   |  |                                      | 22. Name and Address of Facility<br><b>WM. REESE &amp; SONS MORTUARY, P.A.<br/>821 WEST ST. ANNAPOLIS, MD. 21401</b>   |   |   |  |  |
|   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |  |                                      |  |   |   |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |   |  |                                      |  |   |   |  |  |
| Physician<br>/Medical<br>Examiner   | Immediate Cause (Final disease or condition resulting in death)<br>e. <b>SEPTIC SHOCK</b><br>Due to (or as a consequence of):   |   |  |                                      |  |   |   |  |  |
|   | b. <b>DIABETES MELLITUS</b><br>Due to (or as a consequence of):   |   |  |                                      |  |   |   |  |  |
|   | c.<br>Due to (or as a consequence of):  |   |  |                                      |  |   |   |  |  |
|   | d.<br>Due to (or as a consequence of):  |   |  |                                      |  |   |   |  |  |
|   | Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |   |  |                                      |  |   |   |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CEREBRAL VASCULAR ACCIDENT</b>   |   |  |                                      |  |   |   |  |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |                                      |  |   |   |  |  |
|   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |                                      |  |   |   |  |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |                                      |  |   |   |  |  |
|   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |                                      |  |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day Year)                           |  | 28b. Time of Injury<br><b>M</b>      |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><i>Angela Davis</i> MD |  | 29c. License number<br><b>043977</b> |  | 29d. Date signed (Month, Day, Year)<br><b>DECEMBER 5 1997</b>                               |   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Angela Davis, 301 Hospital Drive, GLEN BURIE, MD. 21061</b> |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 09 1997</b>   |   | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>      |  |                                      |  |   |   |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39546

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Irma Elizabeth Hopkins

2. Date of Death  
Month Day Year

December 6 1997

3. Time of Death

10:35AM

4a. Facility Name (If not Institution, give street and number)

Genesis Elder Care Center Spa Creek

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

213-64-0101

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb 21 1905

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

318 State Street

10f. Zip Code

21403

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

18b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Archabold Spriggs

18. Mother's Name (First, Middle, Maiden Surname)

Bessy E. Shepard

19a. Informant's Name/Relationship (Type, Print)

Vernon Hopkins (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

205 Woods Drive Annapolis, Maryland 21403

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Cedar Bluff Cemetery

Date

12/9/97

20c. Location - City or Town, State

Annapolis, Maryland

21. Signature of Funeral Service Licensee

John M. Taylor Funeral Home, Inc.

22. Name and Address of Facility

147 Duke of Gloucester St. Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Valvular heart Disease

Approximate Interval Between Onset and Death

Many years.

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):  
Arteriosclerosis, general a coronary

Many years.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus, type II

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Charles W. Kimber

29c. License number

D05928

29d. Date signed (Month, Day, Year)

December 8, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Charles W. Kimber M.D., 2003 medical pkwy Annapolis, MD 21401

31. Date filed (Month, Day, Year)

DEC 10 1997

32. Registrar's Signature

Julia Davidson-Randall

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39547

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JANE ELIZABETH HOFFMAN

2. Date of Death

December 15 1997 10:56 PM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

220-86-8628

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

44 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

March 20 1953

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1384 Marshall Street

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

None

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

None

16b. Kind of Business/Industry

None

17. Father's Name (First, Middle, Last)

Jacob Lee Hoffman

18. Mother's Name (First, Middle, Maiden Surname)

Doris A. McCauley

19a. Informant's Name/Relationship (Type, Print)

Doris A. Hoffman - Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13243 Salem Church Road Hagerstown, Md. 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rest Haven Cemetery

Date

12-18-97

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

Scott Minnick

22. Name and Address of Facility

Minnich Funeral Home  
415 E. Wilson Blvd. Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Septic Shock

Due to (or as a consequence of):

b.

Perforated Small Intestine

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

30 hrs.

36 hrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Charles R. Chaney MD

29c. License number

D1439F

29d. Date signed (Month, Day, Year)

12/15/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles R. Chaney MD 363 S. Cleveland Hagerstown, Maryland 21740

31. Date filed (Month, Day, Year)

DEC 17 1997

32. Registrar's Signature

Julia Davidson-Rodell

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39548

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ALEX

HAZEL

2. Date of Death

Month Day Year  
DECEMBER 15, 1997

3. Time of Death

3:13 P

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

Baltimore City

5. Social Security Number

None

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 11, 1997

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

PA.

10b. County

Franklin

10c. City, Town or Location

Greencastle

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13790 - 20 Molly Pitcher Hwy.

10f. Zip Code

17225

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

None

16b. Kind of Business/Industry

None

17. Father's Name (First, Middle, Last)

Brett L. Hazel

18. Mother's Name (First, Middle, Maiden Summa)

Marlynda Eckstine

19a. Informant's Name/Relationship (Type, Print)

Brett Hazel / Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13790 -20 Molly Pitcher Hwy. Greencastle Pa. 17225

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Salem Ridge Mennonite Church Cemetery

Date

12/19/97

20c. Location - City or Town, State

Greencastle, Pa.

21. Signature of Funeral Service Licensee

H. Martin Zimmerman

22. Name and Address of Facility

Zimmerman And Son Funeral Home  
45 S. Carlisle St. Greencastle, Pa. 17225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Severe Congenital Anomalies

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Ectopia Cordis

Due to (or as a consequence of):

4 days

c. Pentalogy of Cantrell

Due to (or as a consequence of):

4 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pulmonary Atresia

Giant Omphalocele

Small Chest and Abdominal Cavity

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of injury

(Month, Day Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Marilee C. Allen MD

29c. License number

D26728

29d. Date signed (Month, Day, Year)

December 16, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARILEE ALLEN MD. THE JOHNS HOPKINS HOSPITAL, BALTIMORE, MD. 21287

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 18 1997

32. Registrar's Signature

Julia Davidson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39549

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARGARET JOSEPHINE HOUCHENS

2. Date of Death  
Month Day Year

DECEMBER 18, 1997

3. Time of Death

5:10 PM

4a. Facility Name (If not institution, give street and number)

ST MARY'S NURSING CENTER

4b. City, Town, or Location of Death

LEONARDTOWN

4c. County of Death

ST MARY'S

Funeral  
Director

5. Social Security Number

577-26-6343

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

June 15 1922

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

St Mary's

10c. City, Town or Location

Leonardtown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

Cedar Lane Road

St Mary's Home for Elderly

10f. Zip Code

20650

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Electronic Technician

16b. Kind of Business/Industry

Aero-space

17. Father's Name (First, Middle, Last)

Harry A. Wynn

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth M. Briggs Wynn

19a. Informant's Name/Relationship (Type, Print)

Mabel E. Williams (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

22711 Ridge Road Germantown, MD 20876

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 12-20-97

Date

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

John A. Eberwein

• M00173

22. Name and Address of Facility

J.H. Eberwein Mortuary

4433 White Pls La White Pls, MD 20695

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Stroke

Due to (or as a consequence of):

b. CAD

Due to (or as a consequence of):

c. COPD

Due to (or as a consequence of):

d.

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

1 week

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

28. Place of Death (Check only one)

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
29. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ashah

29c. License number

D 47066

29d. Date signed (Month, Day, Year)

December 19, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Avani D. Shah, M.D. 22650 Cedar La Ct Leonardtown, MD 20650

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 22 1997

32. Registrar's Signature

John A. Eberwein

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 39550

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Carl Edward Hoffmann, Sr.

2. Date of Death

December 16 1997

3. Time of Death

3:12 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Waldorf Healthcare Center

4b. City, Town, or Location of Death

Waldorf

4c. County of Death

Charles

5. Social Security Number

578-20-2018

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb 5 1912

9. Birthplace (State or Foreign Country)

Wash. DC

Usual Residence of Decedent

10a. State

MD

10b. County

Charles

10c. City, Town or Location

LaPlata

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9450 Silver Oak Rd.

10f. Zip Code

20646

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

Accounting

17. Father's Name (First, Middle, Last)

Fritz Hoffmann

18. Mother's Name (First, Middle, Maiden Surname)

Eva Sweeney Hoffmann

19a. Informant's Name/Relationship (Type, Print)

Eva L. Dawson/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9450 Silver Oak Rd. LaPlata, MD 20646

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cem.

Date

12/19/97

20c. Location - City or Town, State

Brentwood, MD

21. Signature of Funeral Service Licensee

MO0945

22. Name and Address of Facility

AREHART-ECHOLS FUNERAL HOME, PA.

P.O. Box 567 LaPlata, MD 20646

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval Between Onset and Death

days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Slp Pneumorectomy

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D46419

29d. Date signed (Month, Day, Year)

12/17/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHARLENE A LETCHFORD MD 404 E CHARLES ST LA PLATA MD 20646

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 18 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

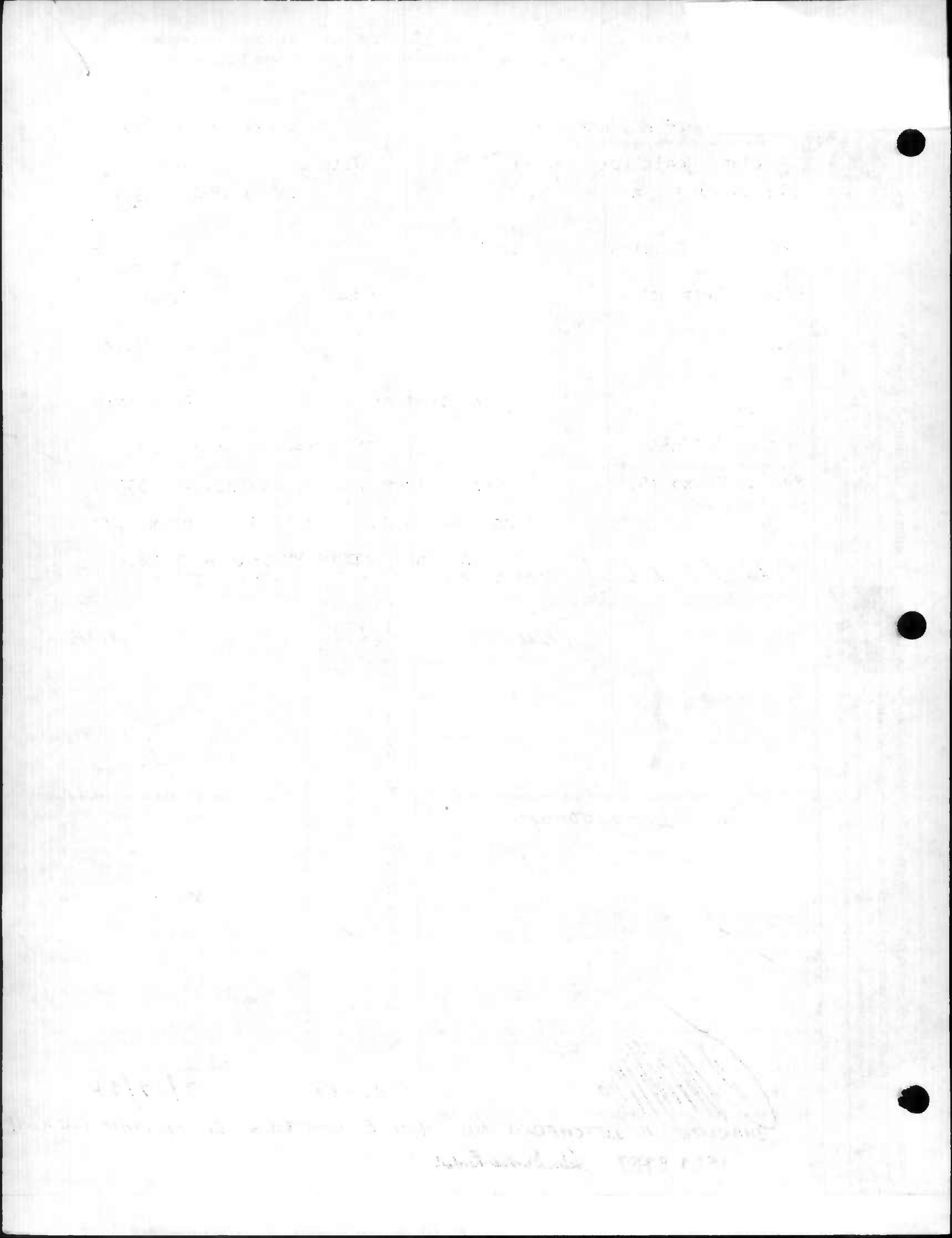
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39551

|  |  |  |   |   |  |                                |  |   |
|--|--|--|---|---|--|--------------------------------|--|---|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br>Eva Mae HASLAM   |  |   |   | 2. Date of Death<br>Month 12 Day 12 Year 97  |                                | 3. Time of Death<br>8PM  |   |
|  | 4a. Facility Name (If not institution, give street and number)<br>Manor Care Nursing Facility  |  |   |   | 4b. City, Town, or Location of Death<br>chevy Chase  |                                | 4c. County of Death<br>Montgomery  |   |
| Funeral<br>Director  | 5. Social Security Number<br>236-30-3282   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>90 Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br>6-9-07  | 9. Birthplace (State or Foreign Country)<br>W.Va. |
|  | Usual Residence of Decedent  |  |   |   |  |                                |  |   |
| To Be Completed by Funeral Director                                  | 10a. State<br>MD.  |  | 10b. County<br>Mont., Co  |   | 10c. City, Town or Location<br>Silver Spring   |                                | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |
|  | 10e. Street and Number<br>14400 Homecrest Rd.  |  |   |   | 10f. Zip Code<br>20906   |                                | 10g. Citizen of What Country?<br>USA   |   |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: white                                   |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Housewife  |   | 16b. Kind of Business/Industry<br>DOMESTIC   |                                |  |   |
|  | 17. Father's Name (First, Middle, Last)<br>Unknown   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Unknown   |                                |  |   |
| To Be Completed by Physician/Medical Examiner                        | 19a. Informant's Name/Relationship (Type, Print)<br>Bruce Haslam   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1433 Q. St. N.W Washington, D.C 20009   |                                |  |   |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Montecito Memorial Pk.  |   | Date<br>12-18  |                                | 20c. Location - City or Town, State<br>Calton, CA.   |   |
|  | 21. Signature of Funeral Service Licensed<br><i>[Signature]</i>  |  | 22. Name and Address of Facility<br>SAMARITAN Funeral Home 1718N. Cap. St. NW Wa., DC. 20001  |   |  |                                |  |   |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. ASPIRATION PNEUMONIA<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |                                |  |   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Rheumatoid Arthritis, Advanced Atherosclerosis<br>Degenerative Joint disease, Dysphagia  |  |   |   |  |                                |  |   |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |                                |  |   |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |   |
|  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28d. Describe how Injury occurred  |                                |  |   |
|  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br><i>[Signature]</i>   |   | 29c. License number<br>D42403  |                                | 29d. Date signed (Month, Day, Year)<br>12-13-97  |   |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>RAJ MATHUR 106 IRVING ST. N.W #202 Washington D-C 20010  |  |   |   |  |                                |  |   |
| State Registrar  | 31. Date filed (Month, Day, Year)<br>DEC 15 1997   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |                                |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



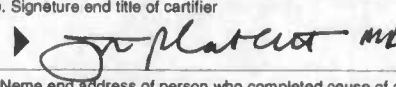
Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

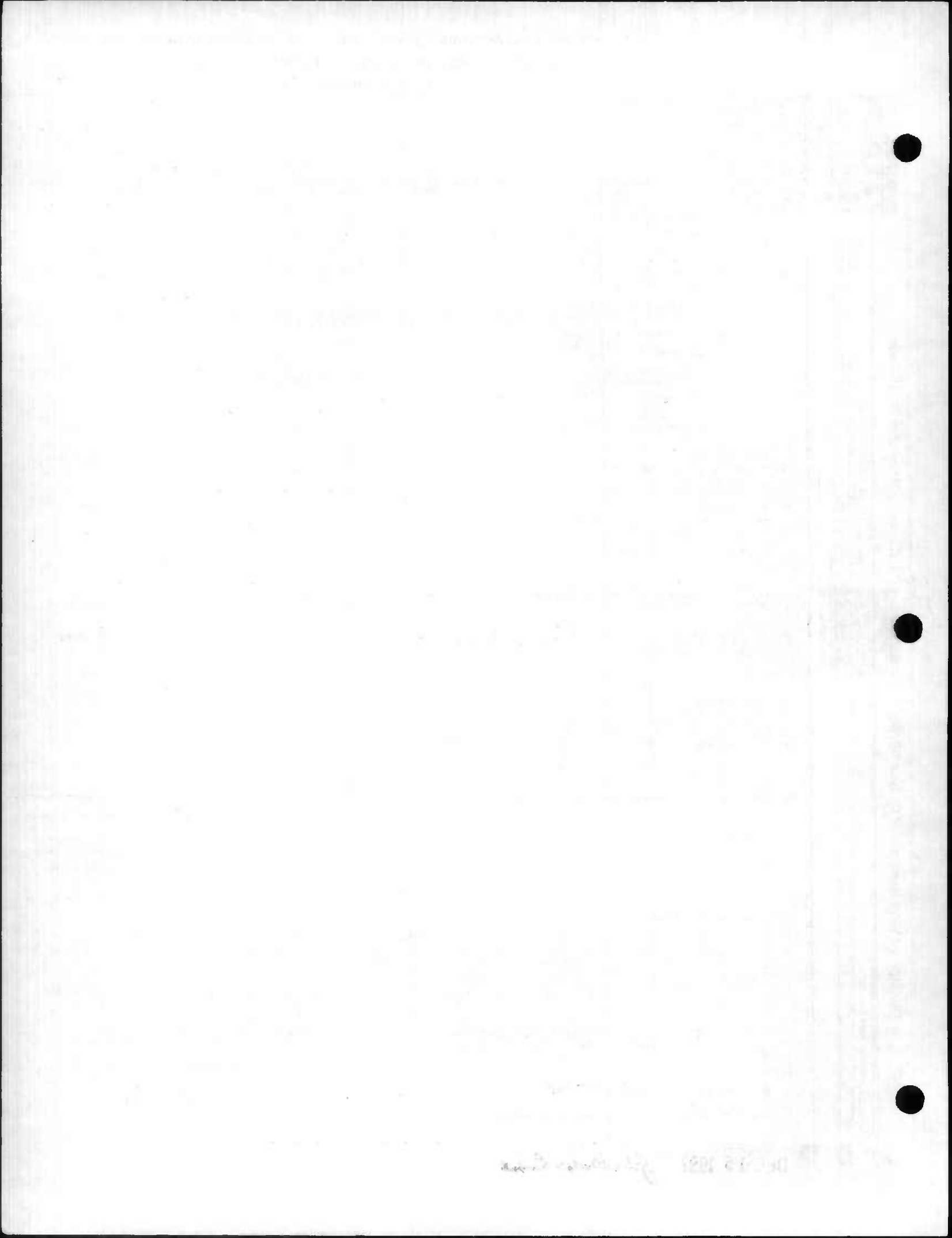
Reg. No.

97 39552

|   |   |   |  |                                     |  |  |   |  |
|---|---|---|--|-------------------------------------|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>BRENDA LOIS HOLMONE</b>  |   |  |                                     | 2. Date of Death<br>Month <b>12</b> Day <b>3</b> Year <b>97</b>  |  | 3. Time of Death<br><b>4:20 P.M.</b>                                    |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>6623 Lacona Street</b>   |   |  |                                     | 4b. City, Town, or Location of Death<br><b>Forestville</b>   |  | 4c. County of Death<br><b>P.G.</b>                                      |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>578-54-8602</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>56</b> Yrs.   | If Under 1 Year<br>Months           | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>5/18/41</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>Wash. D.C.</b>  |
|   | Usual Residence of Decedent   |   |  |                                     |  |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>   | 10b. County<br><b>P.G.</b>  | 10c. City, Town or Location<br><b>Forestville</b>  |                                     |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |
|   | 10e. Street and Number<br><b>6623 Lacona Street</b>   |   |  | 10f. Zip Code<br><b>20747</b>       |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:    |                                     | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary/Admin. Assist. Private</b> |                                     |  | 16b. Kind of Business/Industry   |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>William A. Andrews</b>  |   |  |                                     | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ruby Lane</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Burnette Blandford/sister</b>  |   |  |                                     | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6708 Farmer Dr. Ft. Wash. MD. 20744</b>  |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Harmony Cemetery</b>  |                                     | 20c. Date<br><b>12/8/97</b>  |  | 20d. Location - City or Town, State<br><b>Landover Md.</b>              |  |
|   | 21. Signature of Funeral Service Licensee<br>   |   |  |                                     | 22. Name and Address of Facility<br><b>Hodges and Edwards</b><br><b>3910 Silver Hill RD. Suitland, Md. 20746</b>   |  |   |  |
|   | 23e. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Colon Cancer</b>              |   |  |                                     |  |  |   | Approximate Interval Between Onset and Death<br><b>8 mos</b>   |
|   | 23f. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |   |  |                                     |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |                                     |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |
|   |   |   |  |                                     |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                     |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>     |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred  |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |                                     |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>20547</b> |  | 29d. Date signed (Month, Day, Year)<br><b>12/12/97</b>   |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Joseph Catlett MD. 110 Irving St. N.W. Wash. D.C. 20010</b>  |   |   |  |                                     |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 15 1997</b>   |   | 32. Registrar's Signature<br>  |  |                                     |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39553

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT LEE HOWELL

2. Date of Death

Month Day Year  
12-11-97

3. Time of Death

6:35pm

Funeral  
Director

4a. Facility Name (If not Institution, give street and number)

DOCTORS COMMUNITY HOSPITAL

4b. City, Town, or Location of Death

LANHAM

4c. County of Death

PRINCE GEORGE

5. Social Security Number

578-20-3199

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
8-29-24

9. Birthplace (State or Foreign Country)

TENN

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

NEW CARROLLTON

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5337 85th Ave #202

10f. Zip Code

20784

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: ARMY

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
6

College (1-4or 5+)

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Electrical Maint. Engineer

16b. Kind of Business/Industry

Electrical

17. Father's Name (First, Middle, Last)

LLOYD HOWELL

18. Mother's Name (First, Middle, Maiden Surname)

ANNIE MAUDE NEIGHBORS

19a. Informant's Name/Relationship (Type, Print)

FATIMA HOLMAN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5337 85th Ave #202, New Carrollton, Md. 20784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

George Washington Cem. 12-16-97

Date

20c. Location - City or Town, State

Adelphi, Md.

21. Signature of Funeral Service Licensee

*Paul de Mata*

22. Name and Address of Facility

UNIVERSAL MORTUARY INC.  
411 Kennedy St, N.W., Washington, D.C.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Malignant Ventricular Arrhythmia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 hour

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Ischemic Cardiomyopathy

Due to (or as a consequence of):

2 years

c. Ischemic Heart Disease

Due to (or as a consequence of):

2 years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

MI

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Arvind M. Mehta MD*

29c. License number

D27366

29d. Date signed (Month, Day, Year)

12/11/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARVIND M. MEHTA 7100 Baltimore Ave #504 College Park MD 20740

31. Date filed (Month, Day, Year)

DEC 17 1997

32. Registrar's Signature

*John Anderson*State  
Registrar

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ee Robert L Howell

Baltimore, Maryland 21215-0020

3



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 97 39554

Physician  
/Medical  
ExaminerFuneral  
Director

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. Decedant's Name (First, Middle, Last)<br><b>WALTER Hosey</b>   |  |   | 2. Date of Death<br>Month <b>12</b> Day <b>10</b> Year <b>97</b>   |  | 3. Time of Death<br><b>12:15AM</b>   |
| 4a. Facility Name (If not institution, give street and number)<br><b>Johns Hopkins Bay View</b>   |  |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>Baltimore City</b>   |
| 5. Social Security Number<br><b>124 10 3885</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.  | If Under 1 Year<br>Months Days   | 8. Date of Birth (Month, Day, Year)<br><b>March 19, 1920</b>   | 9. Birthplace (State or Foreign Country)<br><b>New York</b>  |
| Usual Residence of Decedent   |  |   |  |  |  |
| 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Anne Arundel</b>   | 10c. City, Town or Location<br><b>Crofton</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>1947 Pawlet Drive</b>  |  |   | 10f. Zip Code<br><b>21114</b>  | 10g. Citizen of What Country?<br><b>United States</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates.   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Cost Estimator</b>  |  | 16b. Kind of Business/Industry<br><b>Department of Defense</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Walter J. Hosey, Sr.</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rose Immich</b>  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Louise M. Hosey Wife</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1947 Pawlet Drive Crofton Maryland 21114</b> |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. John's Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>Brooklyn New York</b>  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   | 22. Name and Address of Facility<br><b>Robert E. Evans Funeral Home, Inc.<br/>16000 Annapolis Rd. Bowie Md. 20715</b>                            |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. PNEUMONIA</b><br>Due to (or as a consequence of):<br><b>b. CEREBROVASCULAR ACCIDENT</b><br>Due to (or as a consequence of):<br><b>c. MYOCARDIAL INFARCTION</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |   |  |  | Approximate Interval Between Onset and Death<br><b>ONE DAY</b><br><b>EIGHT MONTHS</b><br><b>EIGHT MONTHS</b>   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.  |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
|   |  |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|   |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   | 28b. Time of Injury<br><b>M</b>  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   | 28d. Describe how Injury occurred  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |
| 29b. Signature and title of certifier<br> MD   |  |   | 29c. License number<br><b>RES-000</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>DECEMBER 10, 1997</b>  |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br><b>TOWER 110, 600 N. WOLFE ST., BALTIMORE, MD 21287</b>   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 11 1997</b>   |  |   | 32. Registrar's Signature<br>                                 |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760, S.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Item#2 per PHY G755 1/9/98 EW

Reg. No.

97 39555

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Emily May Hartmeyer

2. Date of Death  
Month Day Year

DECEMBER 12, 1997

3. Time of Death

9:40pm

4a. Facility Name (If not institution, give street and number)

DOCTORS COMMUNITY HOSPITAL

4b. City, Town, or Location of Death

LANHAM

4c. County of Death

PRINCE GEORGE'S

5. Social Security Number

548-05-6804

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 7, 1914

9. Birthplace (State or Foreign Country)

California

Usual Residence of Decedent

10e. State

Maryland

10b. County

10c. City, Town or Location

Bowie

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2218 Hyde Lane

10f. Zip Code

20716

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Edward G. Stevenson

18. Mother's Name (First, Middle, Maiden Surname)

Edith L. Rees

19a. Informant's Name/Relationship (Type, Print)

James T. Hartmeyer/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2218 Hyde Lane Bowie, MD 20716

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

12/15/97

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Robert E. Evans Funeral Home, Inc.  
16000 Annapolis Rd. Bowie, MD 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Cardio-Respiratory Arrest

Approximate Interval Between Onset and Death

10 min

Due to (or as a consequence of):

b.

Recent Myocardial Infarction

3 days

Due to (or as a consequence of):

c.

Coronary artery Disease

Due to (or as a consequence of):

d.

Chronic obstructive pul. Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery disease

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

N/A  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

N/A

28b. Time of Injury

N/A M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

N/A

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

N/A

28f. Location (Street and Number or Rural Route Number, City or Town, State)

N/A

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Mehru Haru Sunde M.D.

29c. License number

D0050514

29d. Date signed (Month, Day, Year)

12/14/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Mehru Haru Sunde, 6510 Kentworth ave, Riverdale, Maryland 20737

31. Date filed (Month, Day, Year)

DEC 17 1997

32. Registrar's Signature

*[Signature]*

State Registrar

Hartmeyer, Emily M  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

4



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39556

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Catherine D. Haas

2. Date of Death

Month Day Year  
December 7, 1997

3. Time of Death

12:00 pm

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

216-22-3336

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 15, 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Arnold

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

704 Southern Hills Drive

10f. Zip Code

21012

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4or 5+)

18a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Supervisor - USNA Laundry

16b. Kind of Business/Industry

United States Naval  
Academy Laundry

17. Father's Name (First, Middle, Last)

Charles M. Haas

18. Mother's Name (First, Middle, Maiden Surname)

Dona C. Hitchens

19a. Informant's Name/Relationship (Type, Print)

Stanley Haas/nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

509 Jumpers Hole Road, Severna Park, MD 21146

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Cedar Hill Cemetery

Date

Dec 11  
1997

20c. Location - City or Town, State

Brooklyn, MD

21. Signature of Funeral Service Licensee

Robert S. B...

22. Name and Address of Facility

Barranco & Sons, P.A. Severna Park Funeral Home  
495 Gov. Ritchie Hwy., Severna Park, MD 2114623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. CARDIO PULMONARY ARREST

Due to (or as a consequence of):

b. ACUTE INTERIOR MI

Due to (or as a consequence of):

c. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

20 MIN

18 HRS

UNKNOWN

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Jon Artschultz MD

29c. License number

D38303

29d. Date signed (Month, Day, Year)

12/7/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jon Artschultz MD

AAMC ANN. MD 2/80/

31. Date filed (Month, Day, Year)

DEC 11 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 must be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39557

|  |   |   |   |  |  |   |  |  |
|--|---|---|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Anthony Joseph Hering   |   |   |  | 2. Date of Death<br>Month Day Year<br>December 8, 1997   |   | 3. Time of Death<br>10:02 pm   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>101 Main Street, Apartment #115   |   |   |  | 4b. City, Town, or Location of Death<br>Secretary  |   | 4c. County of Death<br>Dorchester  |  |
| Funeral<br>Director  | 5. Social Security Number<br>182-24-2311  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>66 Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br>Oct 27, 1931  | 9. Birthplace (State or Foreign Country)<br>Pennsylvania   |  |
|  | Usual Residence of Decedent   |   |   |  |  |   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>MD  | 10b. County<br>Dorchester   |   | 10c. City, Town or Location<br>Secretary                                     |  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
|  | 10e. Street and Number<br>101 Main Street, Apartment #115   |   |   | 10f. Zip Code<br>21664   |  | 10g. Citizen of What Country?<br>USA  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>Certified Public Accountant           |  |  | 18b. Kind of Business/Industry<br>Accounting  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Anthony J. Hering  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Beatrice E. Finnegan  |   |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br>Ann Hering/wife   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>101 Main Street, Apt. 115, Secretary, MD 21664  |   |  |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Cambridge Crematory   |  | Date<br>Dec 10 1997  |   | 20c. Location - City or Town, State<br>Cambridge, MD   |  |
|  | 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br>Barranco & Sons, P.A. Severna Park Funeral Home<br>495 Gov. Ritchie Hwy., Severna Park, MD 21146                  |  |  |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <u>Melanotic K soft tissue Carcinoma</u><br>Due to (or as a consequence of):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |   |   |  |  |   |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 28. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |   |  |  |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |
| 28d. Describe how Injury occurred  |   |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |   |  |  |
| 29e. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |  |  |   |  |  |
| 29b. Signature and title of certifier<br>   |   |   |   | 29c. License number<br>D01865  |  | 29d. Date signed (Month, Day, Year)<br>12/09/97   |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>GERARD CHURCH M.D. 8 EVERGREEN ROAD S.P. MD. 21146   |   |   |   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br>DEC 11 1997   |   | 32. Registrar's Signature<br>  |   |  |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39558

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DAVID

LEE

HELTON

2. Date of Death

Month

Day

Year

DECEMBER

10,

1997

3. Time of Death

12:15 AM

4a. Facility Name (If not institution, give street and number)

4254 BAMFORD COURT

4b. City, Town, or Location of Death

FT. MEADE

4c. County of Death

ANNE ARUNDEL

Funeral  
Director

5. Social Security Number

611-03-7797

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

18 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

JAN. 24, 1979

9. Birthplace (State or Foreign Country)

KENTUCKY

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

FT. MEADE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4254 BAMFORD COURT

10f. Zip Code

20755

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

STUDENT

16b. Kind of Business/Industry

PUBLIC SCHOOL SYSTEM

17. Father's Name (First, Middle, Last)

OSCAR

FRANKIE

HELTON

18. Mother's Name (First, Middle, Maiden Surname)

HYANG

SOON

PARK

19a. Informant's Name/Relationship (Type, Print)

OSCAR FRANKIE HELTON (FATHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4254 BAMFORD COURT, FT. MEADE, MD. 20755

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

NORTH HARDEN MEMORIAL GARDENS

Date

12/13/97

20c. Location - City or Town, State

RADCLIFF, KENTUCKY

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SINGLETON FUNERAL HOME,

1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic osteosarcoma

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

21 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

0101042726

29d. Date signed (Month, Day, Year)

12/10/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

E. Glenn Edwards, Jr. LTC MC Walter Reed Army Wash DC

31. Date filed (Month, Day, Year)

DEC 11 1997

Registrar's Signature

J. Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

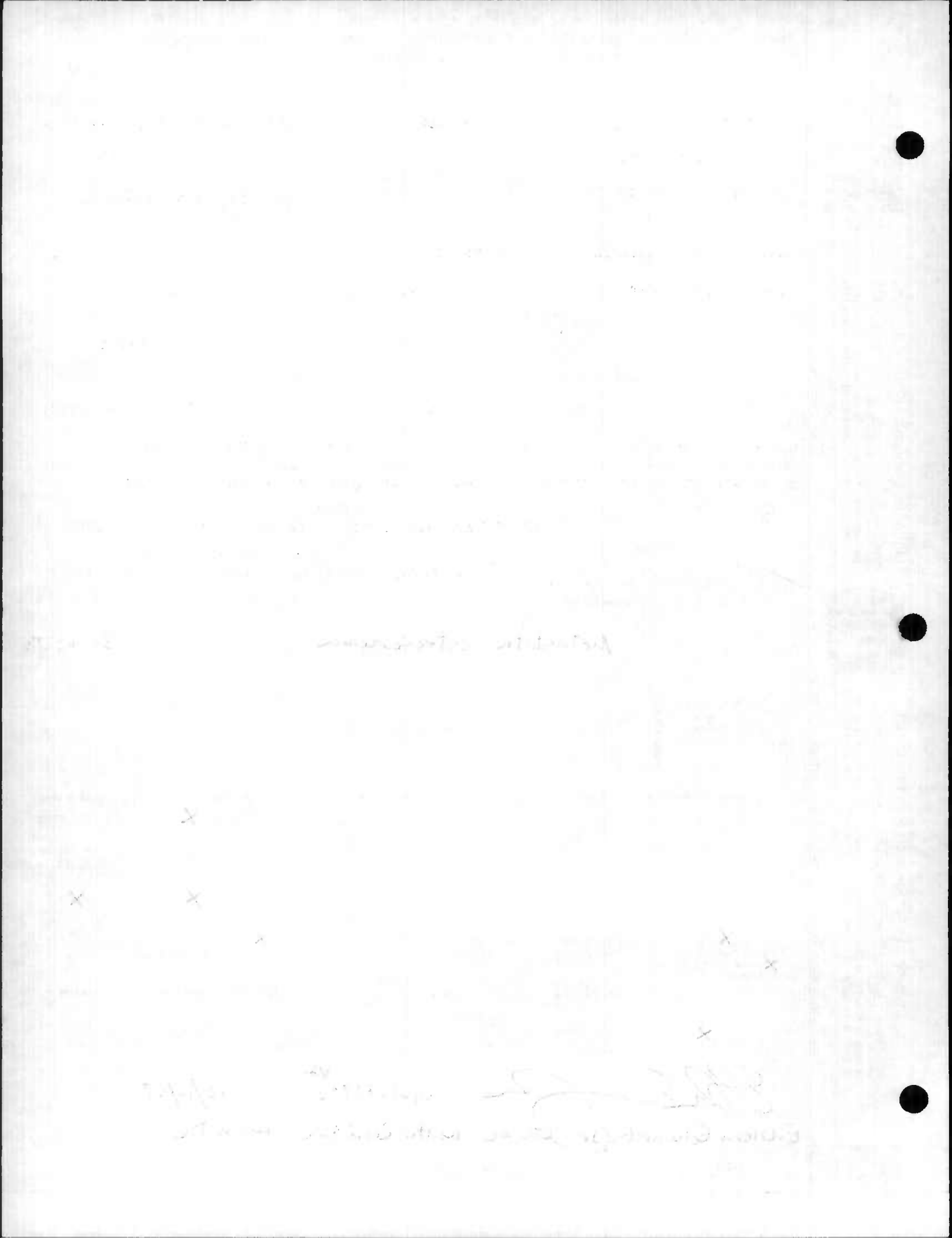
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39559

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ninnie Mae Hughes

2. Date of Death  
Month Day Year

12 04 97

3. Time of Death

10:55 A

4a. Facility Name (If not Institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

432-24-5359

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

September 23, 1914

9. Birthplace (State or Foreign Country)

Arkansas

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12416 Radnor Lane

10f. Zip Code

20708

10g. Citizen of What Country?

United States of America

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

-12-

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Department Store

17. Father's Name (First, Middle, Last)

John Riley Nunaley

18. Mother's Name (First, Middle, Maiden Surname)

Nina Batchelor

19a. Informant's Name/Relationship (Type, Print)

Martha Hughes Wilson - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12416 Radnor Lane Laurel, MD 20708

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Belzoni City Cemetery

Date

12/8/97

20c. Location - City or Town, State

Belzoni, Mississippi

21. Signature of Funeral Service Licensee #M00690

Howard A. Carson

22. Name and Address of Facility

Mortimer Funeral Home

212 Hayden Street, Belzoni, Mississippi 39038

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration pneumonia  
Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Gastroesophageal Reflux  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's dementia

Hematuria of unknown cause

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Marked Goldner MD

29c. License number

D22123

29d. Date signed (Month, Day, Year)

12/4/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 12 1997

32. Registrar's Signature

Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 39560

## Certificate of Death

Reg. No.

|   |  |   |  |  |  |  |   |   |  |
|---|--|---|--|--|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>James William Hutton</b>                    |   |  |  | 2. Date of Death<br>Month <b>12</b> Day <b>17</b> Year <b>1997</b> |  | 3. Time of Death<br><b>6:45 AM</b>                    |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>1972 Whiteford Rd</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Street</b>              |  | 4c. County of Death<br><b>Harford</b>                 |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>213-44-9317</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.                   |  | 8. Date of Birth (Month, Day, Year)<br><b>6/15/22</b> |   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>                                |   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Harford</b>                                      |  | 10c. City, Town or Location<br><b>Street</b>          |   |  |
| Usual Residence of Decedent   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>1972 Whiteford Road</b>   |  | 10f. Zip Code<br><b>21154</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>                               |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>          |   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b></b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Farmer</b>  |  | 16b. Kind of Business/Industry<br><b>Agriculture</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Walter Hutton</b>                  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lonie Leonard</b> |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Tressie M. Hutton- wife</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1972 Whiteford Rd., Street, MD 21154</b>   |  |  |   |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Bel Air Mem. Gdns.</b>   |  | 20c. Date<br><b>12/20/97</b>   |  | 20d. Location - City or Town, State<br><b>Bel Air, MD</b>                        |   |   |  |
| 21. Signature of Funeral Service Licensee<br><i>John H. Tillett</i>   |  |   |  | 22. Name and Address of Facility<br><b>Harkins F.H. Inc., Delta, PA 17314</b>  |  |  |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  | a. <b>Acute exacerbation congestive heart failure 2 weeks</b><br>Due to (or as a consequence of):   |  | b. <b>Acute Respiratory failure</b><br>Due to (or as a consequence of):  |  | c. <b>Sepsis ?</b><br>Due to (or as a consequence of):                           |   | d. <b></b>  |  |
| Approximate Interval Between Onset and Death  |  | 1 week  |  | 1 week   |  |  |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Obstructive Pul. Disease</b><br><b>Diabetes Mellitus</b><br><b>lung mass</b><br><b>Cellulitis/peripheral Vascular Disease</b>  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |  |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   | 28d. Describe how injury occurred   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                       |  | 29b. Signature and title of certifier<br><i>Baz Mirza A. Baig MD</i>  |  | 29c. License number<br><b>D43115</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>12-12-97</b>                           |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Mirza A. Baig 165 S. Union Ave Harford Grace MD</b>  |  | 31. Date filed (Month, Day, Year)<br><b>DEC 19 1997</b>   |  | 32. Registrar's Signature<br><i>John A. Riddell</i>  |  |  |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39561

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Leverett Lyle Hinkel

2. Date of Death

Month

Day

Year

December

13

1997

3. Time of Death

0415

4a. Facility Name (If not Institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

386-30-1679

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 7, 1920

9. Birthplace (State or Foreign Country)

Wisconsin

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1313 Saratoga Drive

10f. Zip Code

21015

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1942

1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Board of Education

17. Father's Name (First, Middle, Last)

Horton Elvin Hinkel

18. Mother's Name (First, Middle, Maiden Surname)

Amy Mae Giesey

19a. Informant's Name/Relationship (Type, Print)

Marguerite B. Hinkel/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1313 Saratoga Drive, Bel Air, Maryland 21015

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harford Memorial Gardens

Data

20c. Location - City or Town, State

12-17-97 Aberdeen, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Howard K. McComas III Funeral Home, P.A.

1317 Cokesbury RD, Abingdon, Maryland 21009

23a. Part I. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. RUPTURED ESOPHAGUS

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 Days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SMALL CELL LUNG CANCER

CRITICAL CORONARY ARTERY DISEASE

NEUTROPENIC SEPSIS

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D 31775

29d. Date signed (Month, Day, Year)

DECEMBER 14, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

31. Date filed (Month, Day, Year)

DEC 16 1997

32. Registrar's Signature

J. Randall

State Registrar

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

12x1

Hinkel, Leverett



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39562

|  |   |  |  |                                |  |
|--|---|--|--|--------------------------------|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Barney Devern Hoosier</b>  |  | 2. Date of Death<br>Month <b>December</b> Day <b>12</b> Year <b>1997</b>   |                                | 3. Time of Death<br><b>3:40 P.M.</b>   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Harford Memorial Hospital</b>  |  | 4b. City, Town, or Location of Death<br><b>Havre de Grace</b>  |                                | 4c. County of Death<br><b>Harford</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>245-34-1541</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|  | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 7, 1924</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>North Carolina</b>  |                                |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent   |  | 10a. State<br><b>Maryland</b>  |                                | 10b. County<br><b>Harford</b>  |
|  | 10c. City, Town or Location<br><b>Street</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                                |  |
|  | 10e. Street and Number<br><b>3611 Conowingo Road</b>  |  | 10f. Zip Code<br><b>21154</b>  |                                | 10g. Citizen of What Country?<br><b>USA</b>  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+)                        |                                | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Laborer</b>  |
|  | 16b. Kind of Business/Industry<br><b>State Government</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Frank (U/K) Hoosier</b>  |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Dore (U/K) Stanley</b>   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Richard Hoosier - son</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3611 Conowingo Rd., Street, Maryland 21154</b> |                                |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Bel Air Memorial Gardens 12-16-97 Bel Air, Maryland</b>               |                                | 20c. Location - City or Town, State  |
|  | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Howard K. McComas III Funeral Home, P.A.<br/>1317 Cokesbury Rd, Abingdon, Maryland 21009</b>                |                                |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediata Cause (Final disease or condition resulting in death)<br><b>a. MRSA Pneumonia</b><br><b>b. Lung Cancer (Rt Lung)</b><br><br>Sequentially list conditions, if any, leading to Immediata causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |  |                                |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.   |   |  |  |                                |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |  |  |                                |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |                                |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |                                |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |                                |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   |  |  |                                |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   |  |  |                                |  |
| 28a. Date of Injury (Month, Day Year)<br><b>28b. Time of Injury</b><br><b>28c. Injury at Work?</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><b>28d. Describe how injury occurred</b><br><b>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</b><br><b>28f. Location (Street and Number or Rural Route Number, City or Town, State)</b>                |   |  |  |                                |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |  |                                |  |
| 29b. Signature and title of certifier<br><b>Rakesh K Mathur MD INTENSIVIST</b>   |   |  |  |                                |  |
| 29c. License number<br><b>D-39170</b>  |   |  |  |                                |  |
| 29d. Date signed (Month, Day, Year)<br><b>12 December, 97</b>  |   |  |  |                                |  |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br><b>RAKESH K MATHUR, HARFORD MEMORIAL HOSPITAL, HAVRE DE GRACE, MD</b>  |   |  |  |                                |  |
| 31. Data filed (Month, Day, Year)<br><b>DEC 16 1997</b>  |   |  |  |                                |  |
| 32. Registrar's Signature<br>  |   |  |  |                                |  |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39563

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES ELDER HUGHES

2. Date of Death

December 10, 1997

3. Time of Death

7:15 AM

4a. Facility Name (If not institution, give street and number)

1124 Chesapeake Drive, Apt. 12D

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

401-48-2220

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

60

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 29, 1937

9. Birthplace (State or Foreign Country)

Kentucky

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Havre de Grace

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1124 Chesapeake Drive, Apt. 12D

10f. Zip Code

21078

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
9

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Press Shoe Operator

16b. Kind of Business/Industry

Shoe Manufacturing

17. Father's Name (First, Middle, Last)

William Nicholas Hughes

18. Mother's Name (First, Middle, Maiden Surname)

Neva (nmn) Blair

19a. Informant's Name/Relationship (Type, Print)

Annie Hughes - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1124 Chesapeake Drive, Apt. 12D, Havre de Grace, MD 21078

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Bel Air Memorial Gardens 12-13-97 Bel Air, Maryland

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Charles A. Emge

22. Name and Address of Facility

Howard K. McComas III Funeral Home, P.A.  
1317 Cokesbury Rd., Abingdon, MD 2100923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

Multiple Myeloma

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

4 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

N/A

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Clarence Smith MD

29c. License number

038878

29d. Date signed (Month, Day, Year)

12/4/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Clarence Smith MD

601 S. Union Ave. Havre de Grace

31. Date filed (Month/Day, Year)

12/11/97

32. Registrar's Signature

John Andrew Randall

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

DEC 16 1997



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

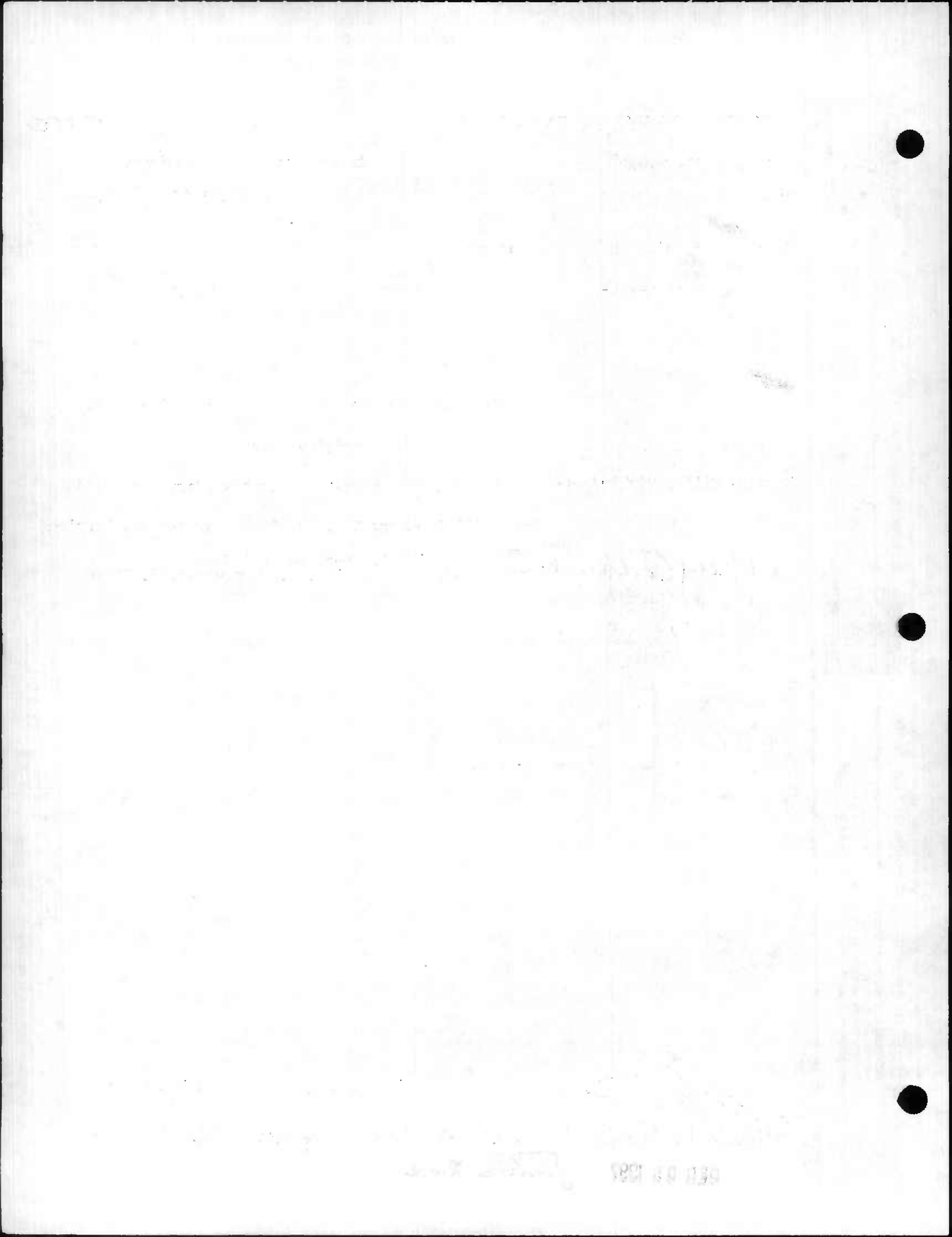
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39564

|   |   |  |  |  |   |  |  |  |
|---|---|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>THOMAS RANDALL HINKLE</b>  |  |  |  | 2. Date of Death<br>Month <b>Dec.</b> <b>3</b> , Day <b>1997</b> Year   |  | 3. Time of Death<br><b>0700</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>844 Marshall Street</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Hagerstown</b>   |  | 4c. County of Death<br><b>Washington</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>219-66-0724</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>42</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>May 24, 1955</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Washington</b>   |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Washington</b>  |  | 10c. City, Town or Location<br><b>Hagerstown</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  | 10e. Street and Number<br><b>844 Marshall Street</b>  |  | 10f. Zip Code<br><b>21740</b>  |  |
|   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:      |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b> <b>College (1-4 or 5+)</b>                       |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Fire Apparatus Operator</b>   |  |  |  | 16b. Kind of Business/Industry<br><b>City Fire Dept.</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>Russell Hinkle</b>   |  |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Shirley Bark</b>  |  |  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Barbara Miller Hinkle/ Wife</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>844 Marshall Street Hagerstown, Maryland 21740</b> |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Rose Hill Cemetery Dec. 12, 1997</b>   |  | 20c. Location - City or Town, State<br><b>Hagerstown, Maryland</b>   |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><b>Kelly A. Younker</b>  |  |  |  | 22. Name and Address of Facility<br><b>Douglas A. Fiery Funeral Home<br/>1331 Eastern Blvd. N. Hagerstown, Md. 21740</b>  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Squamous cell carcinoma of mouth</b><br>Due to (or as a consequence of):<br><br><b>b.</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b> |  |  |  | Approximate Interval Between Onset and Death  |  |  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  |  |  | 28a. Date of Injury (Month, Day, Year)<br><b>Dec. 12, 1997</b>  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 28b. Time of Injury<br><b>M</b>   |  |  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |
|   | 28d. Describe how injury occurred   |  |  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29b. Signature and title of certifier<br><b>[Signature]</b>   |  |  |  |
|   | 29c. License number<br><b>D26F06</b>  |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>12/4/97</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Alfred Howard 747 Northern Ave Hagerstown MD 21742</b>   |  |  |  | 31. Date filed (Month, Day, Year)<br><b>DEC 05 1997</b>   |  |  |  |
|   | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |  | State Registrar   |  |  |  |



1921 00 039

1921 00 039

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39565

|   |   |  |   |  |   |  |   |  |  |  |
|---|---|--|---|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>THOMAS JEREMIAH HULL</b>   |  |   |  | 2. Date of Death<br>Month <b>December</b> Day <b>9</b> Year <b>1997</b>   |  |   |  | 3. Time of Death<br><b>3:19 AM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Colton Villa Nursing Home</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Hagerstown</b>   |  |   |  | 4c. County of Death<br><b>Washington</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>212-14-6099</b>   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>82</b>   |  | 8. Date of Birth (Month, Day, Year)<br><b>May 5, 1915</b>     |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |
|   | Usual Residence of Decedent   |  |   |  |   |  |   |  |  |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Washington</b>  |  | 10c. City, Town or Location<br><b>Hancock</b>   |  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|   | 10e. Street and Number<br><b>13708 Hollow Road</b>  |  |   |  | 10f. Zip Code<br><b>21750</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                |  |  |  |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                            |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Construction Worker</b>               |  |   |  | 16b. Kind of Business/Industry<br><b>Construction Company</b> |  |  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>Jeremiah Luther Hull</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Susan Jane Snyder</b>   |  |   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Theodore S. Hull / Nephew</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>13027 Woodburn Drive Hagerstown, Maryland 21742</b>   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Stonebridge Church Cemetery 12-12-1997 Hancock, Maryland</b>             |  | 20c. Location - City or Town, State<br><b>Hagerstown, Maryland</b>  |  | 20d. Date<br><b>12-12-1997</b>                                |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Douglas A. Fiery Funeral Home<br/>1331 Eastern Blvd. N. Hagerstown, Maryland 21742</b>                         |  |   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Pneumonia</b><br>Due to (or as a consequence of):<br><b>b. Dementia</b><br>Due to (or as a consequence of):<br><b>c. X</b><br>Due to (or as a consequence of):<br><b>d. X</b><br><br>Approximate Interval Between Onset and Death<br><b>6 weeks</b><br><b>2 years</b><br><b>1</b><br><b>X</b> |  |   |  |   |  |   |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>none</b>   |  |   |  |   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |   |  |   |  |   |  |  |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |   |  |   |  |  |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)   |  |   |  |   |  |   |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  |   |  |   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 28a. Date of Injury (Month, Day, Year)<br><b>N/A</b>  |  |   |  |   |  |   |  |  |  |
|   | 28b. Time of Injury<br><b>N/A</b> M   |  |   |  |   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |   |  |   |  |  |  |
|   | 28d. Describe how injury occurred<br><b>N/A</b>   |  |   |  |   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>N/A</b>  |  |   |  |   |  |   |  |  |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>N/A</b>  |  |   |  |   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |  |  |  |
|   | 29b. Signature and title of certifier<br>   |  |   |  |   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29c. License number<br><b>D 28365</b>   |  |   |  |   |  |   |  |  |  |
|   | 29d. Date signed (Month, Day, Year)<br><b>12-9-97</b>   |  |   |  |   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>M AN 2 AR J SHARI. 368 MILL STREET HAGERSTOWN MD 21740</b>   |  |   |  |   |  |   |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br><b>DEC 11 1997</b>   |  |   |  |   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature<br>   |  |   |  |   |  |   |  |  |  |
|   | State Registrar   |  |   |  |   |  |   |  |  |  |

100-100000-100000

DEC 11 1983

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39566

|  |  |  |   |  |  |  |  |  |   |    |             |  |    |                              |    |  |    |  |
|--|--|--|---|--|--|--|--|--|---|----|-------------|--|----|------------------------------|----|--|----|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>James Johnson, Jr.   |  |   |  | 2. Date of Death<br>Month Day Year<br>12-16-97   |  | 3. Time of Death<br>8:20 p.                                      |  |   |    |             |  |    |                              |    |  |    |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>The Pines - Genesis ElderCare  |  |   |  | 4b. City, Town, or Location of Death<br>Easton   |  | 4c. County of Death<br>Talbot                                    |  |   |    |             |  |    |                              |    |  |    |  |
| Funeral<br>Director  | 5. Social Security Number<br>720-18-7389   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>82 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>09/27/15                  |  |   |    |             |  |    |                              |    |  |    |  |
|  | 9. Birthplace (State or Foreign Country)<br>Maryland   |  | 10a. State<br>MD  |  | 10b. County<br>Caroline  |  | 10c. City, Town or Location<br>Federalsburg                      |  |   |    |             |  |    |                              |    |  |    |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br>412 Liberty Road Box 18   |  | 10f. Zip Code<br>21632   |  | 10g. Citizen of What Country?<br>United States                   |  |   |    |             |  |    |                              |    |  |    |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |   |    |             |  |    |                              |    |  |    |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11 College (1-4or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Taxi Driver                              |  | 16b. Kind of Business/Industry<br>Taxi Service   |  |  |  |   |    |             |  |    |                              |    |  |    |  |
|  | 17. Father's Name (First, Middle, Last)<br>James D. Johnson, Sr.   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Blanche Sullivan  |  |  |  |   |    |             |  |    |                              |    |  |    |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Bonnie Klaus/Daughter  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33782<br>7301 Tamarind Circle, Pinellas Park, FL   |  |  |  |   |    |             |  |    |                              |    |  |    |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Cambridge Crematory   |  | 20c. Location - City or Town, State<br>Cambridge, MD   |  | 20d. Date<br>12/18   |  |   |    |             |  |    |                              |    |  |    |  |
|  | 21. Signature of Funeral Service Licensee<br>Michael F. Eskow  |  |   |  | 22. Name and Address of Facility<br>Frampton-Hawkins-Eskow Funeral Home<br>PO Box 43, Federalsburg, MD 21632   |  |  |  |   |    |             |  |    |                              |    |  |    |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |  |  |  |   |    |             |  |    |                              |    |  |    |  |
|  | <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td>dehydration</td> <td rowspan="4">           Approximate Interval Between Onset and Death<br/><br/>           days<br/><br/>           year         </td> </tr> <tr> <td>b.</td> <td>chronic lymphocytic leukemia</td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> |  |   |  |  |  |  |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | dehydration | Approximate Interval Between Onset and Death<br><br>days<br><br>year | b. | chronic lymphocytic leukemia | c. |  | d. |  |
|  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | a.   | dehydration   | Approximate Interval Between Onset and Death<br><br>days<br><br>year                   |  |  |  |  |   |    |             |  |    |                              |    |  |    |  |
| b.   |  | chronic lymphocytic leukemia                       |   |  |  |  |  |  |   |    |             |  |    |                              |    |  |    |  |
| c.   |  |  |   |  |  |  |  |  |   |    |             |  |    |                              |    |  |    |  |
| d.   |  |  |   |  |  |  |  |  |   |    |             |  |    |                              |    |  |    |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.   |  |  |   |  |  |  |  |  |   |    |             |  |    |                              |    |  |    |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |  |   |  |  |  |  |  |   |    |             |  |    |                              |    |  |    |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   |  |  |  |  |  |   |    |             |  |    |                              |    |  |    |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |   |  |  |  |  |  |   |    |             |  |    |                              |    |  |    |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   |  |  |  |  |  |   |    |             |  |    |                              |    |  |    |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |   |  |  |  |  |  |   |    |             |  |    |                              |    |  |    |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)              |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |   |    |             |  |    |                              |    |  |    |  |
|  |  | 28d. Describe how Injury occurred                  |   | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |  |  |   |    |             |  |    |                              |    |  |    |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |  |  |  |  |  |   |    |             |  |    |                              |    |  |    |  |
| 29b. Signature and title of certifier<br>M.D.  |  | 29c. License number<br>D25750                      |   | 29d. Date signed (Month, Day, Year)<br>12-17-97  |  |  |  |  |   |    |             |  |    |                              |    |  |    |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Robert D. Sawner M.D. 509 Edgewood Ave Easton, MD 21601  |  |  |   |  |  |  |  |  |   |    |             |  |    |                              |    |  |    |  |
| 31. Date filed (Month, Day, Year)<br>DEC 18 1997   |  | 32. Registrar's Signature<br>John Davidson-Wardell |   |  |  |  |  |  |   |    |             |  |    |                              |    |  |    |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



jhm  
DIANE  
JONES

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland Department of Health and Mental Hygiene

Items: 23 part I, 27, 28a-f per ME0 G-755 1/5/98 <sup>reb</sup> Certificate of Death

Reg. No.

97 39567

Baltimore, Maryland 21215-0020  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

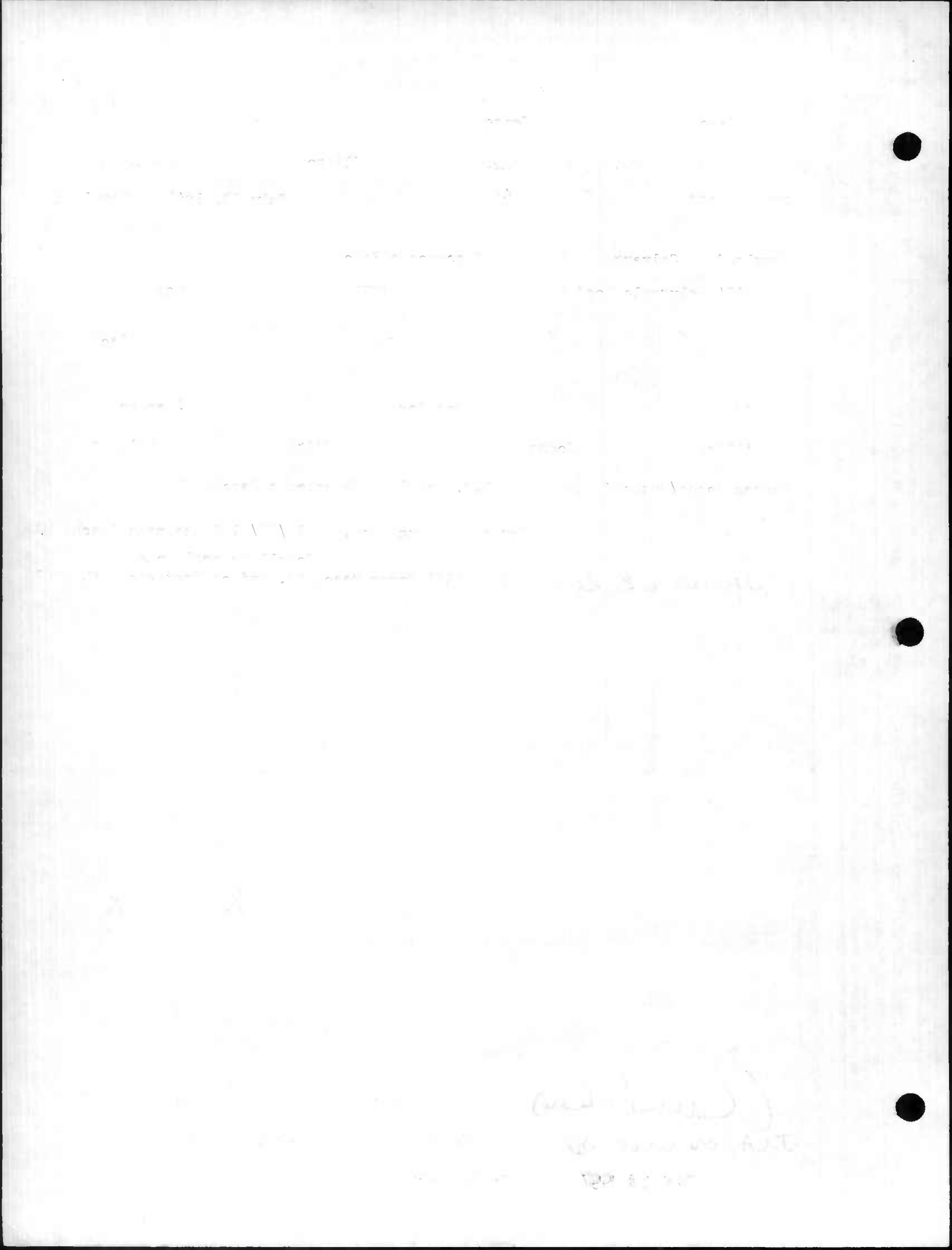
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerFuneral  
DirectorPhysician  
/Medical  
Examiner

|   |  |   |  |   |  |   |   |   |  |
|---|--|---|--|---|--|---|---|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Diane Jones</b>  |  |   |  | 2. Date of Death<br>Month <b>DECEMBER</b> Day <b>10</b> Year <b>1997</b>  |  |   |   | 3. Time of Death<br><b>22:24 PM</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>SOUTHERN MARYLAND HOSPITAL CENTER</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Clinton</b>  |  |   |   | 4c. County of Death<br><b>PRINCE GEORGES</b>  |  |
| 5. Social Security Number<br><b>220-50-9435</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>49</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>July 13, 1948</b>                                 |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |
| Usual Residence of Decedent   |  |   |  |   |  |   |   |   |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Calvert</b>   |  | 10c. City, Town or Location<br><b>Chesapeake Beach</b>  |  |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 10e. Street and Number<br><b>3134 Dalrymple Road</b>  |  |   |  | 10f. Zip Code<br><b>20732</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |   |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Cashier</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Cashier</b>   |  |   | 16b. Kind of Business/Industry<br><b>Pharmacy</b>                       |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>William Jones</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Edith Rawlings</b>  |  |   |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Benson Jones/Husband</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 842 Chesapeake Beach, MD 20732</b>   |  |   |   |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Wards UM Church Cem.</b>   |  | Date<br><b>12/15/97</b>   |   | 20c. Location - City or Town, State<br><b>Chesapeake Beach, MD</b>  |  |
| 21. Signature of Funeral Service Licensee<br><b>Spencer E. Sewell</b>   |  |   |  | 22. Name and Address of Facility<br><b>Sewell Funeral Home<br/>1451 Dares Beach Rd. Prince Frederick, MD 20678</b>  |  |   |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>PERITONITIS</b><br>Due to (or as a consequence of):<br>b. <b>DISLODGEEMENT OF GASTROTOMY TUBE</b><br>Due to (or as a consequence of):<br>c. <b>ESOPHAGEAL MOTILITY DISORDER</b><br>Due to (or as a consequence of):<br>d. <b>POLYMYOSITIS</b> |  |   |  |   |  |   |   | Approximate Interval Between Onset and Death  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.  |  |   |  |   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |   |  |   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)<br><b>tube inserted 12/3/97</b>  |  | 28b. Time of Injury<br><b>unknown</b> M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred<br><b>Infection arising from dislodgement of gastrotomy tube</b>  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Hospital</b>   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Washington, DC<br/>Washington Hospital Center</b>  |  |   |   |   |  |
| 29e. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |   |  |   |   | 29c. License number<br><b>OCME</b>  |  |
| 29b. Signature and title of certifier<br><b>Diane Jones</b>   |  |   |  | 29d. Date signed (Month, Day, Year)<br><b>DECEMBER 12, 1997</b>   |  |   |   |   |  |
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print)<br><b>J-LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201</b>   |  |   |  |   |  |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 16 1997</b>   |  |   |  | 32. Registrar's Signature<br><b>Shirley Ann... Randall</b>  |  |   |   |   |  |

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39568

|  |  |   |   |  |  |  |
|--|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Bernice Jennifer</b>                      |   | 2. Date of Death<br>Month <b>DEC</b> Day <b>11</b> Year <b>1997</b> |  | 3. Time of Death<br><b>7:00 A.M.</b>       |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Knollwood Manor</b> |   | 4b. City, Town, or Location of Death<br><b>Millersville</b>         |  | 4c. County of Death<br><b>Anne Arundel</b> |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>214-76-7916</b>  | 8. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>37</b> Yrs.                    | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.             | 8. Date of Birth (Month, Day, Year)<br><b>June 5, 1960</b>                                     |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                              |   |   |  |  |  |
| Usual Residence of Decedent  |  |   |   |  |  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Severn</b>  |   | 10c. City, Town or Location  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number<br><b>8223 Dunfield Court</b>   |  | 10f. Zip Code<br><b>21144</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br><b>Specify: Black</b>                        |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Medical Assistant</b>   |   | 16b. Kind of Business/Industry<br><b>Nursing Home</b>  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>William A. Brown</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Beatrice E. Thomas</b>  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Beatrice E. Contee/Mother</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 3 Sunderland, MD 20689</b>   |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Ernestine Jones Cem.</b>   |   | 20c. Location - City or Town, State<br><b>12/16/97 Chesapeake Beach, MD</b>  |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Bladyr A. Sewell</b>   |  | 22. Name and Address of Facility<br><b>Sewell Funeral Home<br/>1451 Dares Beach Rd. Prince Frederick, MD 20678</b>  |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |   |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)  |  | a. <b>SEIZURE DISORDER</b>  |   |  |  | Approximate interval Between Onset and Death<br><b>Many yrs</b>                                |
| Due to (or as a consequence of):   |  | b. <b>HISTORY OF ASPIRATION PNEUMONIA</b>   |   |  |  | <b>6 months</b>  |
| Due to (or as a consequence of):   |  | c.  |   |  |  |  |
| Due to (or as a consequence of):   |  | d.  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |   |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |
|  |  | 28d. Describe how Injury occurred   |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |  |  |
| 29b. Signature and title of certifier<br><b>Dr. Misani</b>   |  | 29c. License number<br><b>D40519</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>12. 11. 97.</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MIRZA M. NUSAIRE 7845 OAKWOOD PROF Bldg, Suite 200, Glen Burnie.</b>  |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 16 1997</b>  |  | 32. Registrar's Signature<br><b>Julia Swinson-Randall</b>   |   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

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State of Maryland / Department of Health and Mental Hygiene 97 39569  
Certificate of Death

Reg. No.

|  |   |  |  |   |   |  |  |  |
|--|---|--|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>William F. Jacobs   |  |  | 2. Date of Death<br>Month Day Year<br>December 14, 1997   |   | 3. Time of Death<br>12:18 PM                           |  |  |
|  | 4e. Facility Name (If not institution, give street and number)<br>Suburban Hospital   |  |  | 4b. City, Town, or Location of Death<br>Bethesda  |   | 4c. County of Death<br>Montgomery                      |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>141-22-4798  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                   | 7. Age (In yrs. last birthday)<br>69 Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth<br>(Month, Day, Year)<br>Oct. 4, 1928 | 9. Birthplace (State or Foreign Country)<br>New Jersey                               |  |
|  | Usual Residence of Decedent   |  |  |   |   |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>Maryland  | 10b. County<br>Montgomery  | 10c. City, Town or Location<br>Bethesda  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |
|  | 10e. Street and Number<br>6213 Valley Road  |  | 10f. Zip Code<br>20817   |   | 10g. Citizen of What Country?<br>United States  |  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No World War II                    |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) - College (1-4 or 5+) 5+   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Administrative Law Judge                  |   | 16b. Kind of Business/Industry<br>National Labor Relations Board  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>John Jacobs  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Helen Molz   |   |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Joan M. Jacobs / Wife   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6213 Valley Road, Bethesda, Maryland 20817 |   |  |  |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Montgomery Crematorium, Inc.   |   | 20c. Location - City or Town, State<br>Bethesda, Maryland   |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br> M00689  |  | 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/<br>Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue<br>Bethesda, Maryland 20814-3501 |   |   |  |  |  |
|  | 23a. Part I. State the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Cardio pulmonary Arrest</u><br>Due to (or as a consequence of):<br>b. <u>Sudden Cardiac Death</u><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |   |   |  |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  |   |   |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |  |   |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |  |   |   |  |  |  |
| To Be Completed by Physician/Medical Examiner  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Diabetes Mellitus</u>  |  |  |   |   |  |  |  |
|  | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |   |   |  |  |  |
|  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |   |   |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred  |   |   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |   |   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |  |   |   |  |  |  |
| 29b. Signature and title of certifier<br>   |   | 29c. License number<br>D40453  |  | 29d. Date signed (Month, Day, Year)<br>12/14/97   |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Victoria L. Thornton, M.D. 8600 Old Georgetown Road, Bethesda, Maryland 20814  |   |  |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>DEC 18 1997   |   | 32. Registrar's Signature<br> |  |   |   |  |  |  |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39570

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY SHEA JACQUES

2. Date of Death  
Month Day Year  
DECEMBER 10, 19973. Time of Death  
7:45 PM

4a. Facility Name (If not Institution, give street and number)

CARRIAGE HILL NURSING HOME

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

579-22-1363

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 13, 1903

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Kensington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9600 Dewmar Lane

10f. Zip Code

20895

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Timothy Joseph Shea

18. Mother's Name (First, Middle, Maiden Surname)

Ellen Healey

19a. Informant's Name/Relationship (Type, Print)

Jane Ann Jacques/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9600 Dewmar Lane, Kensington, Maryland 20895

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

12/13/97

20c. Location - City or Town, State

Silver Spring, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home

10 East Deer Park Dr., Gaithersburg, MD. 20877

Physician  
/Medical  
Examiner23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. CEREBRAL VASCULAR ACCIDENT

Due to (or as a consequence of):

b. ARTERIOSCLEROSIS

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

16 DAYS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D11024

29d. Date signed (Month, Day, Year)

DECEMBER 10, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN B. UMHOU, JR., M.D., 8805 CONNECTICUT AVENUE, CHEVY CHASE, MD 20815-6799

31. Date filed (Month, Day, Year)

DEC 15 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

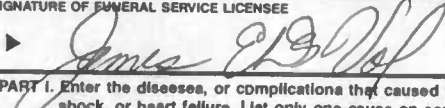

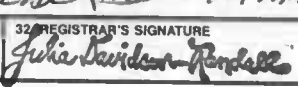
Medical Certification: To Be Completed by Physician/Medical Examiner



97 39571

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ROSA JONES</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>12</b> DAY <b>9</b> YEAR <b>97</b>   |  |  |  | 3. TIME OF DEATH<br><b>1:50 A</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>252-05-0713</b>   |  | 5. SEX<br><b>1</b> <input type="checkbox"/> M <b>2</b> <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>82</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>   |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>  |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>July 29, 1915</b>  |  |  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Georgia</b>  |  |  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Sacred Heart Home</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Hyattsville</b>   |  |  |  | 9c. COUNTY OF DEATH<br><b>Prince George</b>   |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |  |  |   |  |
| 10a. STATE<br><b>none</b>   |  | 10b. COUNTY<br><b>none</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Washington, D.C.</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>3031 Oliver St., N.W.</b>  |  |  |  | 10f. ZIP CODE<br><b>20015</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input checked="" type="checkbox"/> Married<br><b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify: |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b> <b>12</b><br><b>College (1-4 or 5+)</b>  |  |  |  | 18a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>housewife</b>   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>own home</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Xavier Johann</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Hilda Speckert</b>  |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Elaine Collier/daughter</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3031 Oliver St., N.W., Wash., DC 20015</b>  |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Chattanooga National Cem Dec. 12, 97 Chattanooga, Tenn.</b>  |  |   |  | 20c. LOCATION — City or Town, State  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>DeVol Funeral Home</b><br><b>2222 Wisconsin Ave., N.W., Wash., DC 20007</b>  |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MYELODYSPLASTIC SYNDROME</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |  |  | Approximate interval between Onset and Death<br><b>9 MONTHS</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b>   |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO                                   |  |
|   |  |  |  |   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA<br>OTHER: <b>4</b> <input checked="" type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |
| 27. MANNER OF DEATH<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>6</b> <input type="checkbox"/> Pending Investigation<br><b>2</b> <input type="checkbox"/> Accident <b>8</b> <input type="checkbox"/> Could not be determined<br><b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  | 29c. LICENSE NUMBER<br><b>026331</b>  |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>12/9/97</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MARTHA ANNE SCHNEIDER MD 5401 MACARTHUR BLVD NW WASH DC 20016.</b>  |  |  |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 16 1997</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39572

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |  |  |                           |  |   |
|--|--|---|--|--|---------------------------|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><u>Marquerite Jarvis</u>   |  |   |  | 2. Date of Death<br>Month <u>December</u> Day <u>1</u> Year <u>1997</u>  |                           | 3. Time of Death<br><u>1:30 AM</u>   |   |
| 4a. Facility Name (If not institution, give street and number)<br><u>Brooke Grove Nursing Home</u>   |  |   |  | 4b. City, Town, or Location of Death<br><u>Olney</u>   |                           | 4c. County of Death<br><u>Montgomery County</u>  |   |
| 5. Social Security Number<br><u>231-62-3957</u>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><u>93</u> Yrs. | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Hours | 8. Date of Birth (Month, Day, Year)<br><u>May 23, 1904</u>   | 9. Birthplace (State or Foreign Country)<br><u>Virginia</u> |
| Usual Residence of Decedent  |  |   |  |  |                           |  |   |
| 10a. State<br><u>Maryland</u>  |  | 10b. County<br><u>Montgomery County</u>   |  | 10c. City, Town or Location<br><u>Silver Spring</u>  |                           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |
| 10e. Street and Number<br><u>1017 Woodside Parkway</u>   |  |   |  | 10f. Zip Code<br><u>20910</u>  |                           | 10g. Citizen of What Country?<br><u>United States of America</u>   |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                           | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u>  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>5+</u> College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Homemaker</u>  |                           | 16b. Kind of Business/Industry<br><u>Own Home</u>  |   |
| 17. Father's Name (First, Middle, Last)<br><u>Devereaux G. Dunton</u>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Clara Everett Walker</u>   |                           |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>Rita J. Rippey/ Daughter</u>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>1017 Woodside Parkway, Silver Spring, Maryland 20910</u>                                 |                           |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Johnsons Cemetery</u>  |  | Date<br><u>December 6, 1997</u>  |                           | 20c. Location - City or Town, State<br><u>Northampton County Virginia</u>  |   |
| 21. Signature of Funeral Service Licensee<br><u>Howard Carson</u> #M00690  |  | 22. Name and Address of Facility<br><u>B.D. Holland Funeral Service (P.O. Box 188)<br/>7342 Lankford Highway, Nassawadox, VA 23413</u>  |  |  |                           |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><u>a. MYOCARDIAL INFARCTION</u><br>Due to (or as a consequence of):<br><u>b. CORONARY ARTERY DISEASE</u><br>Due to (or as a consequence of):<br><u>c.</u><br>Due to (or as a consequence of):<br><u>d.</u><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |                           |  |   |
| Approximate Interval Between Onset and Death<br><u>HOURS</u><br><u>YEARS</u>   |  |   |  |  |                           |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>CACHEXIA, EMPHYSEMA, OSTEOPOROSIS</u>   |  |   |  |  |                           | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |
|  |  |   |  |  |                           | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |
|  |  |   |  |  |                           | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |                           |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><u>M</u>  |                           | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |                           | 28d. Describe how injury occurred  |   |
|  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |                           |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |                           |  |   |
| 29b. Signature and title of certifier<br><u>K. Howe MD</u>   |  |   |  | 29c. License number<br><u>D33700</u>   |                           | 29d. Date signed (Month, Day, Year)<br><u>December 1, 1997</u>   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>TED E. HOWE 7542 OVERLOOK DRIVE BOONSBORO MD 21713</u>  |  |   |  |  |                           |  |   |
| 31. Date filed (Month, Day, Year)<br><u>DEC 08 1997</u>  |  |   |  | 32. Registrar's Signature<br><u>Julia Davidson-Randall</u>   |                           |  |   |

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39573

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HELEN FAYE JONES

2. Date of Death

Month Day Year  
DECEMBER 14, 1997 11:00p.m.

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

6550 James Lee Drive

4b. City, Town, or Location of Death

Hughesville

4c. County of Death

Charles

5. Social Security Number

455-28-0261

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 3, 1924

9. Birthplace (State or Foreign Country)

Texas

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Hughesville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6550 James Lee Drive

10f. Zip Code

20637

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Administrative Clerk

16b. Kind of Business/Industry

Retail Grocery

17. Father's Name (First, Middle, Last)

Ollie Herrington

18. Mother's Name (First, Middle, Maiden Surname)

Eula Wright

19a. Informant's Name/Relationship (Type, Print)

Marsha Hildebrand - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6550 James Lee drive, Hughesville, MD 20637

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Washington National Cem. 12-19-97

Date

20c. Location - City or Town, State

Suitland, MD

21. Signature of Funeral Service Licensee

Shannon W. Ramirez M00798

22. Name and Address of Facility

Huntt Funeral Home, Inc. P. O. Box 156

Waldorf, MD 20604-0156

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy

performed?

1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

B. Harry Jenkins Jr. M.D.

29c. License number

D-33426

29d. Date signed (Month, Day, Year)

December, 15, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

B. Harry Jenkins Jr. M.D. 111 LaGrange Ave. La Plata, Md 20646

31. Date filed (Month, Day, Year)

DEC 19 1997

32. Registrar's Signature

John Anderson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William DeWalden Jones 11

2. Date of Death

Month  
12Day  
08Year  
97

3. Time of Death

1:20 PM

4a. Facility Name (If not institution, give street and number)

Villa Rosa Nursing Home

4b. City, Town, or Location of Death

Mitchelville

4c. County of Death

Prince Georges

5. Social Security Number

088-03-6705

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 14, 1905

9. Birthplace (State or Foreign Country)

N.C.

Usual Residence of Decedent

10a. State

D.C.

10b. County

none

10c. City, Town or Location

Washington

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1310 42nd Street, S.E.

10f. Zip Code

20020

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
9

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Archivist

16b. Kind of Business/Industry

Commerce Dept.

17. Father's Name (First, Middle, Last)

William DeWalden Jones 1

18. Mother's Name (First, Middle, Maiden Surname)

Jettie Fulp

19a. Informant's Name/Relationship (Type, Print)

Son  
William DeWalden Jones 111

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1310 42nd St. S.E. Wash. D.C. 20020

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lincoln Memorial Cem

Date

12/13

20c. Location - City or Town, State

Suitland, Md.

21. Signature of Funeral Service Licensee

F. Bernard Hunt

22. Name and Address of Facility

Hunt Funeral Home

1420 34th St. S.E. Wash. D.C. 20020

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Due to (or as a consequence of):

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Days  
Months  
Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

No

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOAOther: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Richard J. Feldman MD

29c. License number

D32261

29d. Date signed (Month, Day, Year)

12-8-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richard J. Feldman MD 9505 ANNAPOLIS RD, CARHMAN MD

31. Date filed (Month, Day, Year)

DEC 15 1997

32. Registrar's Signature

John Andrew Barlett

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 39575

Amended # 23, GC, PG, 12/17/07

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

IRENE ISABEL JOSEPH

2. Date of Death  
Month Day Year  
December 12 19973. Time of Death  
10:23 AM

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

220-60-6070

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)

11-17-1906

9. Birthplace (State or Foreign  
Country)

New Amsterdam, Guyana

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bladesburg

10d. Inside City Limits  
1 ☒ Yes 2 ☐ No

10e. Street and Number

5034 57th Avenue, #201

10f. Zip Code

20781

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black'

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 years

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

School Teacher

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Abraham Trim

18. Mother's Name (First, Middle, Maiden Surname)

Letitia Whitfield

19a. Informant's Name/Relationship (Type, Print)

Myrtle P. Grosvenor/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6312 Kennedy Street, Riverdale, Maryland 20737

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

12/16  
1997

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

Nancy A. Peranti

22. Name and Address of Facility

J. B. JENKINS FUNERAL SERVICE  
7474 Landover Road, Landover, Maryland 2078523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. CARDIAC ARREST (HEART FAILURE)

Due to (or as a consequence of):

b. Leukemia (CML)

Due to (or as a consequence of):

c. Thrombocytopenia

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

LEUKEMIA (CML)

THROMBOCYTOPENIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

Inpatient

2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
investigation6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician2 ☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Blayton Thompson MD

29c. License number

D45796

29d. Date signed (Month, Day, Year)

12/14/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1400 SPRING STREET SUITE 200 SILVER SPRING MD 20910

31. Date filed (Month, Day, Year)

DEC 17 1997

32. Registrar's Signature

John A. Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39576

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LEO HOWARD JONES

2. Date of Death

Month Day Year  
DECEMBER 3 1997

3. Time of Death

9:38 PM

Funeral  
Director

4a. Facility Name (If not Institution, give street and number)

302 NORTH MAIN STREET

4b. City, Town, or Location of Death

BOONSBORO

4c. County of Death

WASHINGTON

5. Social Security Number

578-20-8889

6. Sex

XXM 2□F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
01/02/1919

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WASHINGTON

10c. City, Town or Location

BOONSBORO

10d. Inside City Limits

1□ Yes 2□ No  
XX

10e. Street and Number

302 NORTH MAIN STREET

10f. Zip Code

21713

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1□ Never Married 2XX Married  
3□ Widowed 4□ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

XX Yes 2□ No

If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□ Yes XX No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 YEARS

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

PAINTER

16b. Kind of Business/Industry

INTERIOR DESIGN

17. Father's Name (First, Middle, Last)

EARL LESTER CASEY JONES

18. Mother's Name (First, Middle, Maiden Surname)

BEULLA MOATS

19a. Informant's Name/Relationship (Type, Print)

CHARLES F. KAUFFMAN, JR./P.O.A. 416 NORTH MAIN STREET, BOONSBORO, MARYLAND 21713

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

XX Burial 2□ Cremation 3□ Removal from State  
4□ Donation 5□ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BOONSBORO CEMETERY 12/06/1997

Data

20c. Location - City or Town, State

BOONSBORO, MARYLAND

21. Signature of Funeral Service Licensee

P. Steven Danfelt

22. Name and Address of Facility

7606 OLD NATIONAL PIKE  
BAST FUNERAL HOME BOONSBORO, MARYLAND 21713

23a. Part I. Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 HRS

b.

HYPERTENSION

Due to (or as a consequence of):

unknown

c.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILLATION

PITUITARY ADENOMA.

23b. Did tobacco use contribute to the cause of death?

1□ Yes 2□ No 3□ Probably 4□ Unknown

24a. Was an autopsy performed?

1□ Yes 2□ No

24b. Were autopsy findings available prior to completion of cause of death?

1□ Yes 2□ No

25. Was case referred to medical examiner?

1□ Yes 2XX No

26. Place of Death (Check only one)

Hospital:

1□ Inpatient

2□ ER/Outpatient

3□ DOA

Other:

4□ Nursing Home

5XX Residence

8□ Other (Specify)

27. Manner of Death

1□ Natural 5□ Pending investigation  
2□ Accident 6□ Could not be determined  
3□ Suicide 4□ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1□ Yes 2□ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2□ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

P. Steven Danfelt

29c. License number

044996

29d. Date signed (Month, Day, Year)

Dec 4, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ZAPAR MALIK MD 20311 LAPPANS RD BOONSBORO MD 21713

31. Date filed (Month, Day, Year)

DEC 05 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39577

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

THELMA L. KNOTT

2. Date of Death

Month

Day

Year

December 14, 1997

3. Time of Death

11:23AM

4a. Facility Name (If not institution, give street and number)

DOCTORS HOSPITAL

4b. City, Town, or Location of Death

LANHAM

4c. County of Death

PRINCE GEORGES

Funeral  
Director

5. Social Security Number

579-32-6853

6. Sex

1 ☐ M2 ☒ F

7. Age (In yrs. last birthday)

85

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

MAY 12, 1912

9. Birthplace (State or Foreign Country)

WASH. D.C.

Usual Residence of Decedent

10a. State

MD.

10b. County

PRINCE GEORGES

10c. City, Town or Location

GREENBELT

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7010 GREENBELT RD.

10f. Zip Code

20770

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SALES LADY

16b. Kind of Business/Industry

WOODIES

17. Father's Name (First, Middle, Last)

CHARLES E. NAYLOR

18. Mother's Name (First, Middle, Maiden Surname)

FANNIE H. SCAGGS

19a. Informant's Name/Relationship (Type, Print)

CATHY ABBOTT/NIECE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15 EMPIRE PL., GREENBELT, MD. 20770

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CEDAR HILL CEMETERY

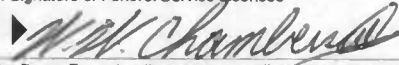
Date

12/17/97

20c. Location - City or Town, State

SUITLAND, MD.

21. Signature of Funeral Service Licensee



M00091

22. Name and Address of Facility

CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Extensive cerebromacular damage

Due to (or as a consequence of):

b. cerebromacular thrombosis

Due to (or as a consequence of):

c.therosclerotic cerebromacular disease

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

4 days

4 days

4 days

4 days

4 days

4 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

fractured left humerus + left femur

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

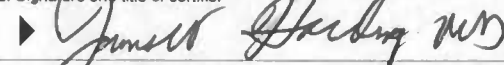
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D05401

29d. Date signed (Month, Day, Year)

December 14, 1997

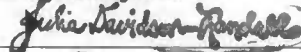
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAMES HARDING MD 7525 GREENWAY CENTER DRIVE, #3K6 GREENBELT, MD 20770

31. Date filed (Month, Day, Year)

DEC 16 1997

32. Registrar's Signature

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39578

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MASON STANLEY KORLIN

2. Date of Death

Month Day Year

DEC 16 97

3. Time of Death

9:00 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

1131 UNIVERSITY BLVD. WEST APT 815 B

4b. City, Town, or Location of Death

WHEATON

4c. County of Death

MONTGOMERY

5. Social Security Number

577-44-0908

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year

JUL 8, 1922

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

WHEATON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1131 UNIVERSITY BLVD W., APT #815B

10f. Zip Code

20902

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No WWII  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SOCIAL WORKER

16b. Kind of Business/Industry

STATE GOVERNMENT

17. Father's Name (First, Middle, Last)

FRANK KOPLIN

18. Mother's Name (First, Middle, Maiden Surname)

MAE KLAUSNER

19a. Informant's Name/Relationship (Type, Print)

RICHARD KOPLIN (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15101 INTERLACHEN DR APT #1001 SILVER SPRING MD 20901

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

QUANTICO NATIONAL CEM.

Date

12/19/97

20c. Location - City or Town, State

QUANTICO, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DANZANSKY-GOLDBERG MEMORIAL CHAPELS INC  
1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Congestive Heart Failure.

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 days

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. atherosclerotic heart Disease

Due to (or as a consequence of):

years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

208546

29d. Date signed (Month, Day, Year)

Dec. 16 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Teuber 8218 W. SCARSON AVE Bethesda

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 19 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39579

|   |   |  |   |  |  |
|---|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Martha L. Kruglak</b>  |  | 2. Date of Death<br>Month <b>Dec.</b> Day <b>17</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>12:30PM</b>   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Suburban Hospital</b>  |  | 4b. City, Town, or Location of Death<br><b>Bethesda</b>   |  | 4c. County of Death<br><b>Montgomery</b>   |
| Funeral<br>Director   | 5. Social Security Number<br><b>130-03-1639</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                       | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.  | If Under 1 Year<br>Months Days                         | If Under 24 Hrs.<br>Hours Min.   |
|   | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 8, 1921</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>NYC</b>  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Md.</b>  |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Rockville</b>  |
|   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |
|   | 10e. Street and Number<br><b>5800 Nicholson Lane</b>  |  | 10f. Zip Code<br><b>20852</b>   |  | 10g. Citizen of What Country?<br><b>US</b>   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |   |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>                     |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Abraham Cohen</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anna Blacken</b>  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Glen Kruglak/ Son</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>21 Bouldercrest Ct. Rockville, Md. 20850</b>  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Beth Shalom Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>Capitol Heights, Md.</b>   |
|   | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Edward Sagel Funeral Direction<br/>1091 Rockville Pike Rockville, Md. 20852</b>                            |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Pneumonia</b><br>Due to (or as a consequence of):<br><br>b. <b>Stroke</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |  |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes mellitus, type II</b>   |   |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)  |   |  |  |
| 28b. Time of Injury<br>M  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                      |   |  |  |
| 28d. Describe how injury occurred   |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                                     |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |  |   |  |  |
| 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>536797</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>12/17/97</b> |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>10215 Pennwood Rd Bethesda MD, 20817</b>   |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 19 1997</b>   |   | 32. Registrar's Signature<br> |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

12

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39580

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Frances H. Kennedy

2. Date of Death

Month Day Year  
Dec. 12, 1997

3. Time of Death

4:30 P.M.

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

029 16 9111

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 2, 1925

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10e. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5132 Flintridge Drive

10f. Zip Code

20784

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16e. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Social Worker Technician

16b. Kind of Business/Industry

Health Care

17. Father's Name (First, Middle, Last)

Joseph Rooney

18. Mother's Name (First, Middle, Maiden Surname)

Marie Louise Marcil

19a. Informant's Name/Relationship (Type, Print)

William J. Kennedy, Sr. Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5132 Flintridge Dr. Hyattsville MD 20784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Maryland Veterans Cemetery

Date

Dec. 17, 1997

20c. Location - City or Town, State

Cheltenham MD

21. Signature of Funeral Service Licensee

*James K. Gorman*

22. Name and Address of Facility

Robert E. Evans Funeral Home, Inc.  
16000 Annapolis Rd. Bowie Md. 2071523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

*Acute myocardial Infarction*

Due to (or as a consequence of):

b.

*Coronary artery Disease*

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

1 day

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Sick sinus syndrome*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28e. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

*S. Chaturathi MD*

29c. License number

D 52119

29d. Date signed (Month, Day, Year)

12/13/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

SPRIDHAR CHATURATHI Suite 302, 8100 Good Luck Rd, Lanham MD 20706

31. Date filed (Month, Day, Year)

DEC 17 1997

32. Registrar's Signature

*[Signature]*State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39581

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) RUTH GERALDINE KENNEDY 2. Date of Death Month Day Year DECEMBER 6, 1997 3. Time of Death 10:15 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number) ROCK GLEN NURSING & REHABILITATION CENTER 4b. City, Town, or Location of Death BALTIMORE 4c. County of Death N/A

5. Social Security Number 220-09-6175 6. Sex 1 ☐ M 2 ☒ F 7. Age (In yrs. last birthday) 77 Yrs. 8. Date of Birth (Month, Day, Year) JULY 20, 1920 9. Birthplace (State or Foreign Country) MARYLAND

Usual Residence of Decedent

10a. State MARYLAND 10b. County N/A 10c. City, Town or Location BALTIMORE 10d. Inside City Limits 1 ☒ Yes 2 ☐ No

10e. Street and Number 1120 SPENCE STREET 10f. Zip Code 21230 10g. Citizen of What Country? U.S.A.

11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) N/A 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER 16b. Kind of Business/Industry OWN HOME

17. Father's Name (First, Middle, Last) FREDERICK SAMUEL MICHAEL 18. Mother's Name (First, Middle, Maiden Surname) RELLA RAMBLE

19a. Informant's Name/Relationship (Type, Print) WILLIAM R. KENNEDY, JR. (SON) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 406 GRAYSLAKE WAY, ABERDEEN, MARYLAND 21001

20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) CHESAPEAKE CREMATORY, INC. 12/10/97 BELTSVILLE, MD. 20c. Location - City or Town, State

21. Signature of Funeral Service Licensee 22. Name and Address of Facility SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

23a. Pert1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Metastatic Cancer Due to (or as a consequence of): carcinoma of breast

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last f. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier 29c. License number D21649 29d. Date signed (Month, Day, Year) Dec. 8, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAMBANDAN BASKARAN, 3455 Wilkens Ave. Baltimore MD 21229

31. Date filed (Month, Day, Year) DEC 11 1997 32. Registrar's Signature Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary T. KELLY

2. Date of Death

December 2 1997

3. Time of Death

11:58 PM

4a. Facility Name (If not institution, give street and number)

Howard County Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

157-10-7696

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 14, 1913

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

New

10b. County

Essex

10c. City, Town or Location

Upper Montclair

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

17 Chester Road

10f. Zip Code

07043

10g. Citizen of What Country?

United States of America

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify:

White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Municipal

17. Father's Name (First, Middle, Last)

John Larkin

18. Mother's Name (First, Middle, Maiden Surname)

Ann Maliniff

19a. Informant's Name/Relationship (Type, Print)

Jack Kelly

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17 Chester Road Upper Montclair, NJ 07043

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Holy Cross Cemetery

Date

Dec. 6,  
1997

20c. Location - City or Town, State

North Arlington, NJ

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Greenville Memorial Home

374 Danforth Avenue Jersey City, NJ 07305

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Pneumonia

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
investigation6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D22856

29d. Date signed (Month, Day, Year)

December 3, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JERRY L. LEWIS, MD 11055 Little Porters Rd, Columbia Md. 21044

31. Date filed (Month, Day, Year)

DEC 12 1997

32. Registrar's Signature

John Davidson-Randall

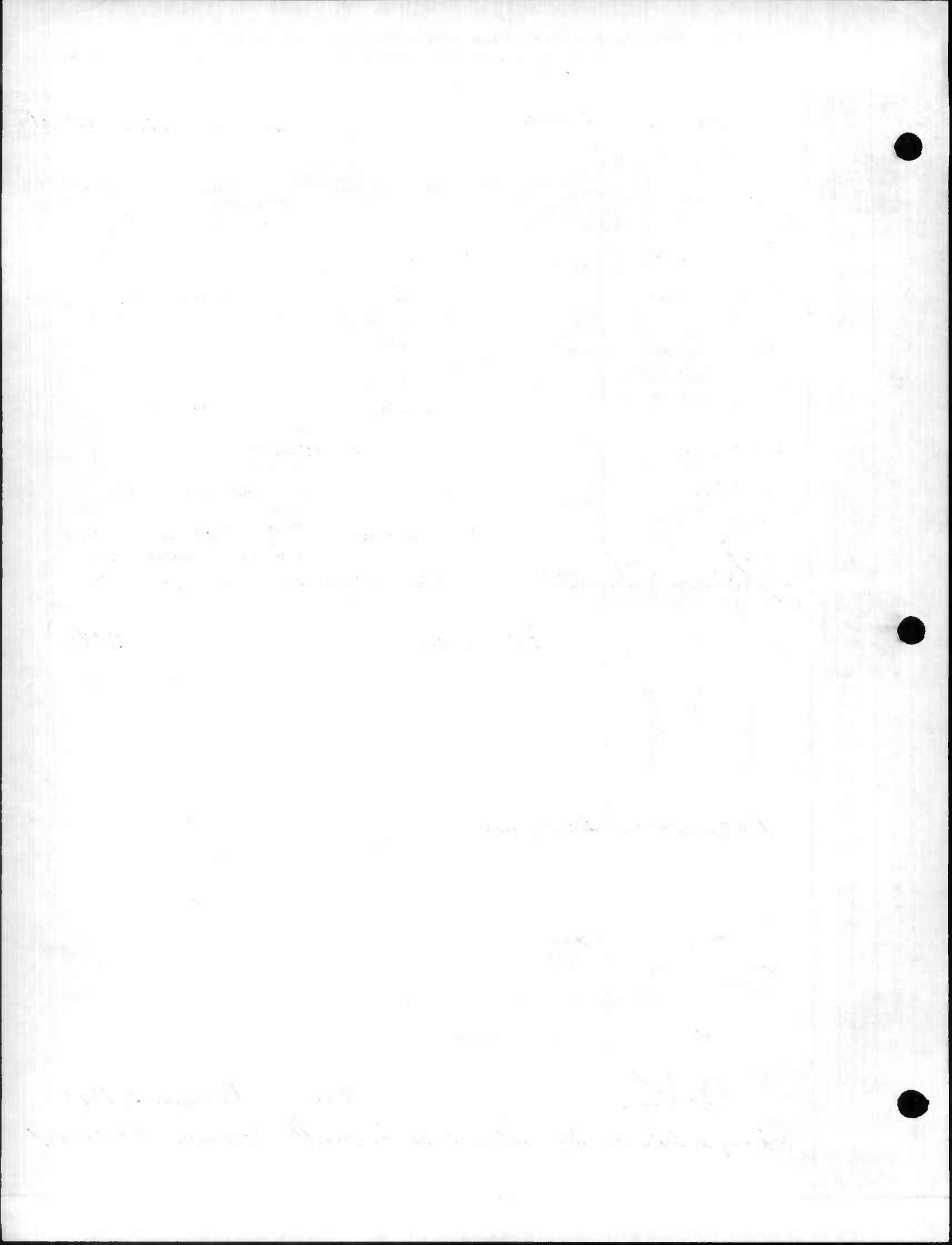
State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ida Alberta KUHN

2. Date of Death

Month Day Year  
December 7, 1997

3. Time of Death

3:00 p.m.

4a. Facility Name (If not institution, give street and number)

16931 Shadybrook Terrace

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

219-20-4966

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)  
June 9, 1910

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

16931 Shadybrook Terrace

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
6College (1-4 or 5+)  
016a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

her own home

17. Father's Name (First, Middle, Last)

Mervin A. Knouse

18. Mother's Name (First, Middle, Maiden Surname)

Annie Lobaugh

19a. Informant's Name/Relationship (Type, Print)

Arlene Hoover

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11723 Robinwood Dr., Hagerstown, Md. 21742

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Rest Haven Cemetery

Date

12-10-97

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

MINNICH FUNERAL HOME

415 E. Wilson Blvd., Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

arteriosclerotic heart disease

Approximate  
Interval Between  
Onset and Death

years

Due to (or as a consequence of):

congestive heart failure

3-4 weeks

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D01062

29d. Date signed (Month, Day, Year)

Dec. 8, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Edward W. Ditto, III, M.D., 217 W. Washington St., Hagerstown, Md. 21740

31. Date filed (Month, Day, Year)

DEC 09 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

2010年10月10日

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 39584

## Certificate of Death

Reg. No.

|   |   |  |   |                                       |  |   |  |  |
|---|---|--|---|---------------------------------------|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Bobby Eugene Knable</b>  |  |   |                                       | 2. Date of Death<br>Month <b>December</b> Day <b>12</b> Year <b>1997</b>   |   | 3. Time of Death<br><b>0343</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>The Johns Hopkins Hospital</b>   |  |   |                                       | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |   | 4c. County of Death<br><b>Baltimore</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>218-30-9182</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |                                       | 7. Age (In yrs. last birthday)<br><b>62</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>December 1934</b>                                    |  |
|   | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Washington</b>  |                                       | 10c. City, Town or Location<br><b>Hagerstown</b>   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent<br>10e. Street and Number<br><b>12024 Smithfield Farm Lane</b>  |  |   |                                       | 10f. Zip Code<br><b>21740</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                       | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                        |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>0-10</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>correctional officer</b>          |                                       | 16b. Kind of Business/Industry<br><b>state prison</b>  |   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Lewis C. Knable</b>   |  |   |                                       | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Olive Virginia Robinson</b>  |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. Ronald Knable/son</b>  |  |   |                                       | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>25514 Brooks Avenue, Cascade, Maryland 21719</b>   |   |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Shanktown Cemetery</b>   |                                       | 20c. Location - City or Town, State<br><b>Dec 15, 1997 Big Pool, Maryland</b>  |   |  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Scott M. Minnich</b>  |  |   |                                       | 22. Name and Address of Facility<br><b>Minnich Funeral Home<br/>415 East Wilson Blvd., Hagerstown, Maryland 21740</b>  |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Myocardial Infarction</b><br>Due to (or as a consequence of):<br><b>b. Coronary Artery Disease</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter underlying cause (Disease or injury that initiated events resulting in death) Last<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |   |                                       |  |   |  |  |
|   | Approximate Interval Between Onset and Death<br><b>twelve hours</b><br><b>twenty years</b>  |  |   |                                       |  |   |  |  |
|   | Physician<br>/Medical<br>Examiner   | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.<br><b>Diabetes Mellitus</b><br><b>Hypertension</b><br><b>Intermittant Atrial Fibrillation</b> |   |                                       |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|   |   |  |   |                                       |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
|   |   |  |   |                                       |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |                                       |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br><b>M</b>       |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |   | 28d. Describe how injury occurred     |  |   |  |  |
| 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |                                       |  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |                                       |  |   |  |  |
| 29b. Signature and title of certifier<br><b>Donald A. Dibbern, Jr., MD</b>  |   |  |   | 29c. License number<br><b>RES-000</b> |  | 29d. Date signed (Month, Day, Year)<br><b>December 12, 1997</b>   |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Donald A. Dibbern, Jr., MD Johns Hopkins Hospital 601 N Wolfe St Baltimore MD 21204</b>  |   |  |   |                                       |  |   |  |  |
| State<br>Registrar  | 31. Date filed (Month, Day, Year)<br><b>DEC 15 1997</b>   |  |   |                                       | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>   |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: if item 27 is marked other than "Natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39585

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Nancy Jane KROUSE

2. Date of Death

Month Day Year  
December 12, 1997

3. Time of Death

7:00 AM

4a. Facility Name (If not institution, give street and number)

122 West Side Avenue

4b. City, Town, or Location of Death

Funkstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

213-18-8316

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 29, 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Funkstown

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

122 West Side Avenue

10f. Zip Code

21734

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
0-12College (1-4 or 5+)  
016a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

packing and shipping

16b. Kind of Business/Industry

shoe mfg.

17. Father's Name (First, Middle, Last)

Clarence J. Reeher

18. Mother's Name (First, Middle, Maiden Surname)

Helen L. Boward

19a. Informant's Name/Relationship (Type, Print)

Mr. Paul E. Krouse/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

122 West Side Avenue, Funkstown, Maryland 21734

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Funkstown Cemetery

Date

Dec 15, 1997

20c. Location - City or Town, State

Funkstown, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Minnich Funeral Home

415 East Wilson Blvd., Hagerstown, Maryland 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cancer of Colon with Liver Metastases

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

28. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D11133

29d. Date signed (Month, Day, Year)

Dec 15, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11110 Medical Campus Rd Hagerstown MD 21742

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 15 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



jhm  
Wilson Keyser  
Levering

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39586

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Physician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Wilson Keyser Levering, III</b>   |  |   |  | 2. Date of Death<br>Month <b>DECEMBER</b> Day <b>13</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>23:55 PM</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>CARROLL COUNTY GENERAL HOSPITAL</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Westminster</b>   |  | 4c. County of Death<br><b>CARROLL</b>  |  |
| 5. Social Security Number<br><b>216-38-4431</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>58</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Nov 2, 1939</b>  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Carroll</b>   |  | 10c. City, Town or Location<br><b>Westminster</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>661 Whispering Meadows Court</b>  |  |   |  | 10f. Zip Code<br><b>21158</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1964-67</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Drivers Exam Administrator</b>   |  | 16b. Kind of Business/Industry<br><b>Motor Vehicle Admn.</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Wilson Keyser Levering</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Roslind Robinson</b>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Carolyn Levering (Wife)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>661 Whispering Meadows Ct., Westminster, MD 21158</b>                                    |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>Entombment</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lake View Mausoleum</b>  |  | Date<br><b>12/17/97</b>  |  | 20c. Location - City or Town, State<br><b>Sykesville, MD</b>   |  |
| 21. Signature of Funeral Service Licensee<br><b>Brian L. Hay</b>   |  |   |  | 22. Name and Address of Facility<br><b>HAIGHT FUNERAL HOME &amp; CHAPEL (Box 195)<br/>Sykesville, MD 21784 (410)-795-1400</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Combined drug intoxication</b><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  | Approximate Interval Between Onset and Death   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)<br><b>12-13-97</b>   |  | 28b. Time of Injury<br><b>2:30</b> M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  | 28d. Describe how injury occurred<br><b>Subject took prescription drugs</b>   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>661 Whispering Meadows Ct Westminster, Carroll County, MD</b>   |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br><b>Donald G. Wright MD</b>   |  | 29c. License number<br><b>OCME</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>DECEMBER 15, 1997</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201</b>  |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 16 1997</b>  |  |   |  | 32. Registrar's Signature<br><b>J. A. Anderson</b>   |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39587

|   |   |  |  |  |   |  |  |  |
|---|---|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>LLOYD BLAND LEEBRICK</b>   |  |  |  | 2. Date of Death<br>Month <b>December</b> Day <b>14</b> , Year <b>1997</b>  |  | 3. Time of Death<br><b>8:20p.m.</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>ST MARY' COUNTY HOSPITAL</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>LEONARDTOWN</b>  |  | 4c. County of Death<br><b>ST MARY'S</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>578-24-2471</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>72</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>April 20, 1925</b>                                       |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b>  |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>St Mary's</b>   |  | 10c. City, Town or Location<br><b>Leonardtwn</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>22680 Cedar Lane Court #1222</b>  |  | 10f. Zip Code<br><b>20650</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW 11</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                            |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Truck Driver</b>                               |  | 16b. Kind of Business/Industry<br><b>Concrete Industry</b>  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Frank Leebrick</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Clara M. DeLorme Leebrick</b>   |  |  |  |
| Physician<br>/Medical<br>Examiner             | 19a. Informant's Name/Relationship (Type, Print)<br><b>Joyce M. Trickett (Sister)</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>304 Main Street Extended Accident, MD 21520</b>   |  |  |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Maryland Veterans' Cem.</b>   |  | 20c. Location - City or Town, State<br><b>12-23-97 Cheltenham, MD</b>   |  | 20d. Date  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><b>John H. Eberwein</b>  |  | 22. Name and Address of Facility<br><b>J.H. Eberwein Mortuary</b><br><b>4433 White Pls La White Pls., MD 20695</b>   |  | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>a. cardiac arrest</b><br>Due to (or as a consequence of):<br><b>b. Myocardial infarction</b><br>Due to (or as a consequence of):<br><b>c. congestive heart failure</b><br>Due to (or as a consequence of):<br><b>d.</b> |  | Approximate Interval Between Onset and Death<br><b>few min.</b><br><b>1 wk</b><br><b>long time</b> |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |
|   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  |
|   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28b. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.    |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier<br><b>Dr. Avani D. Shah</b>   |  | 29c. License number<br><b>D 47066</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>12-15-97</b>  |  |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Dr. Avani D. Shah Hollywood, MD. 20636</b>   |  |  |  |   |  |  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>DEC 17 1997</b>   |  | 32. Registrar's Signature<br><b>John Anderson Randall</b>  |  |   |  |  |  |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39588

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ROSE MARIE

2. Date of Death

Month

Day

Year

DECEMBER 13, 1997

3. Time of Death

2345 PM

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

548-28-9400

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

February 11, 1913

9. Birthplace (State or Foreign Country)

Canada

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

Washington, DC

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1255 New Hampshire Avenue, NW, #1029

10f. Zip Code

20036

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Psychologist

16b. Kind of Business/Industry

Private Practice

17. Father's Name (First, Middle, Last)

Norman Gordon

18. Mother's Name (First, Middle, Maiden Surname)

Rae Gordon

19a. Informant's Name/Relationship (Type, Print)

Felicia Emad

(daughter) 20900 Sunnyacres Road, Laytonsville, MD 20882

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

12-16-97

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Kapp Funeral Services, P.A.

933 Gist Avenue, Silver Spring, Maryland 20910

23a. Pertinent: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Duodenal Obstruction

Due to (or as a consequence of):

b. Pancreatic Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 month  
3 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

26a. Date of Injury

(Month, Day, Year)

26b. Time of Injury

M

26c. Injury at Work?

1 ☐ Yes 2 ☐ No

26d. Describe how injury occurred

26a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

26f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D24994 (MD)

29d. Date signed (Month, Day, Year)

December 14, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark Birns, MD 9711 Medical Center Drive Rockville, MD 20850

31. Date filed (Month, Day, Year)

DEC 16 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39589

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT EDWIN LEDBETTER

2. Date of Death

Month Day Year  
12/ 12/ 97

3. Time of Death

6:45 AM

4e. Facility Name (If not Institution, give street and number)

Villa Rosa Nursing Home

4b. City, Town, or Location of Death

Mitchellville

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

017-18-9401

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 2, 1919

9. Birthplace (State or Foreign Country)

Alabama

Usual Residence of Decedent

10e. State

Florida

10b. County

Hillsborough

10c. City, Town or Location

Tampa

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15344 Pond Woods Drive, East

10f. Zip Code

33618

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16e. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Electrical Engineer

16b. Kind of Business/Industry

Aerospace

17. Father's Name (First, Middle, Last)

Robert Ernest Ledbetter

18. Mother's Name (First, Middle, Maiden Surname)

Frances Saunders

19a. Informant's Name/Relationship (Type, Print)

Lori Ledbetter/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15344 Pond Woods Drive, East  
Tampa, Florida 33618

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)December 15, 1997  
Montgomery Crematorium, Inc.

Date

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

Ray Jank

M00198

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Rockville, Inc.  
300 West Montgomery Avenue  
Rockville, Maryland 20850-280523e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Alzheimer's Disease

Due to (or as a consequence of):

b. Parkinson's Disease

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Deathyears,  
years,

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Azotemia.

Neurogenic Dysphagia.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☐ Could not be determined28e. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Rakesh Arora, MD

29c. License number

D 20108

29d. Date signed (Month, Day, Year)

12/12/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

RAKESH ARORA, M.D. 14300 GALLANT FOX LANE BOWIE, MD 20715

31. Date filed (Month, Day, Year)

DEC 17 1997

32. Registrar's Signature

Julia Davidson-Rendell

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
15

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39590

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

King Sau Lee

2. Date of Death

Month Day Year  
December 14, 1997

3. Time of Death

10:30 PM

4a. Facility Name (If not institution, give street and number)

4819 Aspen Hill Road

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

219-78-1782

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

47 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 19, 1950

9. Birthplace (State or Foreign Country)

China

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4819 Aspen Hill Road

10f. Zip Code

20853

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Chinese

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Cashier

16b. Kind of Business/Industry

Food Service

17. Father's Name (First, Middle, Last)

Ying Fook Lem

18. Mother's Name (First, Middle, Maiden Surname)

Yuet Ming Yee

19a. Informant's Name/Relationship (Type, Print)

Ho Ming Lee / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4819 Aspen Hill Road, Rockville, Maryland 20853

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Parklawn Memorial Park

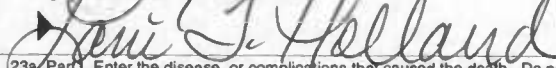
Date

12/20/97

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Hines-Rinaldi Funeral Home  
11800 New Hampshire Avenue  
Silver Spring, Maryland 2090423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

10 mos

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier



29c. License number

C89291

29d. Date signed (Month, Day, Year)

December 15, 1997

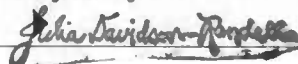
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frederick Smith, M.D. 5401 Western Avenue, N.W., Washington, D.C. 20015

31. Date filed (Month, Day, Year)

DEC 18 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

THE UNIVERSITY OF CHICAGO PRESS  
CHICAGO, ILL. 60637  
U.S.A.

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CHICAGO, ILL. 60637  
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State of Maryland / Department of Health and Mental Hygiene 97 39591

## Reg. No.

DMMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39592

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Henry Lockley

2. Date of Death

Month

Day

Year

December 14, 1997

3. Time of Death

1949

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

218 24 9881

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

June 28 1931

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

329 Henry Avenue

10f. Zip Code

21740

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 7/48-52

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Hotel

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Emma Lockley Carroll

19a. Informant's Name/Relationship (Type, Print)

Ms. Francis Lockley/Cousin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

318 N Prospect St. Hagerstown, MD 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Rose Hill Cemetery

Date

12/18/97

20c. Location - City or Town, State

Hagerstown, MD.

21. Signature of Funeral Service Licensee

Thomas E. Watts

22. Name and Address of Facility

Watsons Funeral Home

24 WBethel St. Hagerstown, MD. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CANCER OF COLON WITH lung

Due to (or as a consequence of):

metastases

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes and nephrosclerosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

H.N. Weeks

29c. License number

D11266

29d. Date signed (Month, Day, Year)

Dec 15 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H.N. Weeks 580 Northon Ave Hagerstown, MD

31. Date filed (Month, Day, Year)

DEC 18 1997

32. Registrar's Signature

Julia Burden Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

1000 1000 1000

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39593

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MURRILL LEWIS

2. Date of Death

December 16, 1997

3. Time of Death

5:56 AM

4a. Facility Name (If not institution, give street and number)

DOCTORS HOSPITAL

4b. City, Town, or Location of Death

LANHAM

4c. County of Death

P.G. COUNTY

Funeral  
Director

5. Social Security Number

227-58-6244

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

53

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

October 31, 1944

9. Birthplace (State or Foreign Country)

Hague, VA

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

Washington, DC

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4426 14th St., NE

10f. Zip Code

20017

10g. Citizen of What Country?

United States

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates: UNKNOWN

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Procurement Specialist

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Russell Lewis

18. Mother's Name (First, Middle, Maiden Surname)

Helena Lewis

19a. Informant's Name/Relationship (Type, Print)

AARON LEWIS / BROTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11703 LOCUST DALE CT. MITCHELLVILLE MD 20716

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

POTOMAC BAPT. CH CEMETERY 12-20-97 HAGUE VIRGINIA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Larry P. Simmons

22. Name and Address of Facility

Alexander S. Pope Funeral Home  
2617 Pennsylvania Ave, SE, Washington, DC 20020

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Intra Cerebral Hemorrhage

Due to (or as a consequence of):

11 days

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Uncontrolled Hypertension

Due to (or as a consequence of):

11 days

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Earl M. Armstrong

29c. License number

D19993

29d. Date signed (Month, Day, Year)

December 16, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Earl M. Armstrong, MD 7227A Hanover Parkway, Greenbelt, MD 20770

31. Date filed (Month, Day, Year)

DEC 19 1997

32. Registrar's Signature

Earl M. Armstrong

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

MURRILL BENJAMIN LEWIS  
Baltimore, Maryland 21215-0020  
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended # 20 12/15/97 P.D.D. ELM Certificate of Death

Reg. No.

97 39594

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ALIEN P

LAWRENCE

2. Date of Death

Month Day Year  
DEC 10, 1997

3. Time of Death

5:47pm

4a. Facility Name (If not institution, give street and number)

SOUTHERN MARYLAND HOSPITAL

4b. City, Town, or Location of Death

CLINTON

4c. County of Death

PRINCE GEORGES

5. Social Security Number

239-16-9639

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

June 29, 1908

9. Birthplace (State or Foreign Country)

N. Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Upper Marlboro

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4706 COLONEL EWELL COURT

10f. Zip Code

20772

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LABORER

16b. Kind of Business/Industry

PRIVATE

17. Father's Name (First, Middle, Last)

NATHANIEL H. LAWRENCE

18. Mother's Name (First, Middle, Maiden Surname)

REBECCA BRIDGES

19a. Informant's Name/Relationship (Type, Print)

ROBERT LAWRENCE/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13318 BURLEIGH ST. UPPER MARLBORO, MD 20774

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

NORTHEASTERN CEMETERY

Date

12-17

20c. Location - City or Town, State

ROCKY MT., N. CAROLINA

21. Signature of Funeral Service Licensee

Juanara L. Braxton

22. Name and Address of Facility

MARSHALL'S FUNERAL HOME

4308 SUITLAND ROAD SUITLAND, MD 20746

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Septic Shock - Uro sepsis

Due to (or as a consequence of):

2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Urinary Tract Infection

Due to (or as a consequence of):

2 days

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure, Respiratory Failure, Renal Failure, Multi-Stroke Dementia

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Richard A. Farson MD

29c. License number

DO 2237 MD

29d. Date signed (Month, Day, Year)

12/11/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richard A. Farson MD 12825 Old Fort Rd Ft. Wash. MD 20744

31. Date filed (Month, Day, Year)

DEC 15 1997

32. Registrar's Signature

J. Anderson-Rodriguez

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

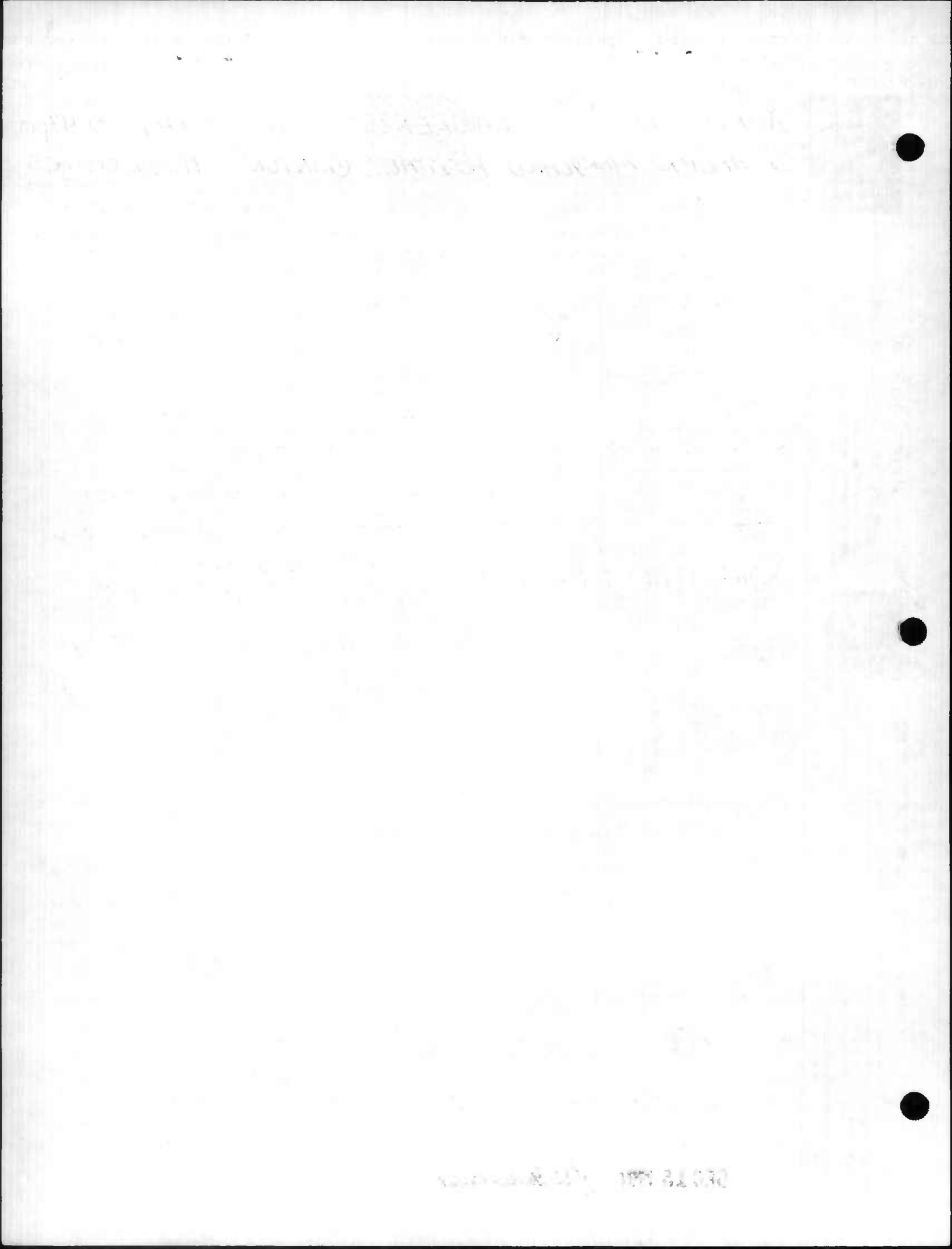
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 39595

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DORA ROBERTA LARKINS

2. Date of Death

Month Day Year  
DECEMBER 11 1997

3. Time of Death

1:58 PM

4a. Facility Name (If not institution, give street and number)

Doctors Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

218-16-0783

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 30, 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

12904 Duckettown Road

10f. Zip Code

20719

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

John Porter

18. Mother's Name (First, Middle, Maiden Surname)

Maggie Shepherd

19a. Informant's Name/Relationship (Type, Print)

Garfield Larkins / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12904 Duckettown Road, Bowie, Maryland 20719

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

12/18 1997

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

Nancy A. Peacanti

22. Name and Address of Facility

J.B. JENKINS FUNERAL HOME  
7474 Landover Road, Landover, Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC PULMONARY ARREST MINUTES

Due to (or as a consequence of):

b. PULMONARY EMBOLUS MINUTES

Due to (or as a consequence of):

c. POST OPERATIVE INGUINAL HERNIA 5 WEEKS

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

NEPHRECTOMY FOR HYPERNEPHROMA

THORACIC ABDOMINAL AORTIC ANEURYSM

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D31069

29d. Date signed (Month, Day, Year)

12-11-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DR GEORGE BONE 9602F ML KING JR HIGHWAY LANHAM, MD 20706

31. Date filed (Month, Day, Year)

DEC 16 1997

32. Registrar's Signature

[Signature]

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

DORA LARKINS

CR



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39596

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William Littleton

2. Date of Death

Month  
12Day  
14Year  
97

3. Time of Death

8:00 AM

4a. Facility Name (If not institution, give street and number)

Mariner Health of Southern Maryland

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

5. Social Security Number

216-12-4569

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
06-24-19

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Prince George's10c. City, Town or Location  
Upper Marlboro

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9801 Williamsburg Drive

10f. Zip Code

20772

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6th

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Printing

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

William H. Littleton

18. Mother's Name (First, Middle, Maiden Surname)

Rosie Thomas

19a. Informant's Name/Relationship (Type, Print)

Thomas Littleton/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9801 Williamsburg Drive, Upper Marlboro MD 20772

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Harmony Memorial Park

Date

12/18/97

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

Charles J. Boumas

22. Name and Address of Facility

J. B. Jenkins Funeral Home

7474 Landover Road, Landover, Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Coronary Artery disease &  
Due to (or as a consequence of):b. myocardial infarction  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

24h

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury et  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Laxmi Berwa, M.D., 7700 Old Branch Avenue C101, Clinton, MD 20735

31. Date filed (Month, Day, Year)

DEC 17 1997

32. Registrar's Signature

John A. ...

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
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To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39597

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

CELIMA LOUVET

2. Date of Death  
Month Day Year  
December 15 19973. Time of Death  
10:55 p

4a. Facility Name (If not institution, give street and number)

St. Thomas Nursing Home

4b. City, Town, or Location of Death

Hyattsville

4c. County of Death

Prince George's

5. Social Security Number

577-06-8455

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
June 29, 1907

9. Birthplace (State or Foreign Country)

Haiti

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Brentwood

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3302 40th Place

10f. Zip Code

20722

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

1st

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Alcius Louvet

18. Mother's Name (First, Middle, Maiden Surname)

Cinelia Evallard

19a. Informant's Name/Relationship (Type, Print)

Carlo Camille/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3302 40th Place, Brentwood, Maryland 20722

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ft. Lincoln Cemetery

Date

12/20/97

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

Charles J. Louvet

22. Name and Address of Facility

J. B. Jenkins Funeral Home

7474 Landover Road, Landover, Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Years

Due to (or as a consequence of):

b. Syndrome of Inappropriate ADH

1 Year

Due to (or as a consequence of):

c. ASCVD

Years

Due to (or as a consequence of):

d. HBP

Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Senile Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. B. Patrick III MD

29c. License number

D17729

29d. Date signed (Month, Day, Year)

December 16, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G. B. Patrick III, M.D., 9221 Colesville Road, Silver Spring MD 20910

31. Date filed (Month, Day, Year)

DEC 18 1997

32. Registrar's Signature

J. B. Patrick III

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

2



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39598

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last)

RAYMOND DEWEY LEWIS

2. Date of Death

Month Day Year  
Dec. 14 1997

3. Time of Death

6:35 pm

4a. Facility Name (If not institution, give street and number)

3414 Hughes Road

4b. City, Town, or Location of Death

Darlington

4c. County of Death

Harford

5. Social Security Number

227-24-3631

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

(Month, Day, Year)  
9/27/1925

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Darlington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3414 Hughes Road

10f. Zip Code

21034

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Unknown

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Pump mechanic

16b. Kind of Business/Industry

Repair

17. Father's Name (First, Middle, Last)

Otis M. Lewis

18. Mother's Name (First, Middle, Maiden Surname)

Lizzie Williams

19a. Informant's Name/Relationship (Type, Print)

Elva Cleo Johnson/Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3414 Hughes Road, Darlington, MD 21034

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rest Haven Mem. Gdns. 12/16 Frederick, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*Jeffrey P. Lovelace*

22. Name and Address of Facility

Harkins Funeral Home, Inc., Delta, PA

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ASCVD

Due to (or as a consequence of):

b. COPD

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Esophageal structure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. and manner stated.

29b. Signature and title of certifier

*Ashok K. Narang MD*

29c. License number

D24070

29d. Date signed (Month, Day, Year)

12/15/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ashok K. Narang, M.D., 2 North Avenue, Suite 102, Bel Air, MD 21014

31. Date filed (Month, Day, Year)

DEC 16 1997

32. Registrar's Signature

*John Michael Randall*

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39599

|   |   |   |   |                                      |  |   |  |   |   |  |   |
|---|---|---|---|--------------------------------------|--|---|--|---|---|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><i>Ida Rae Leatherman</i>   |   |   |                                      | 2. Date of Death<br>Month <i>December</i> Day <i>5</i> Year <i>1997</i>  |   |  |   | 3. Time of Death<br><i>9:05 A.M.</i>    |  |   |
|   | 4a. Facility Name (If not Institution, give street and number)<br><i>12630 Brandenburg Hollow Rd.</i>   |   |   |                                      | 4b. City, Town, or Location of Death<br><i>Myersville</i>  |   |  |   | 4c. County of Death<br><i>Frederick</i> |  |   |
| Funeral<br>Director   | 5. Social Security Number<br><i>215-36-6968</i>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><i>100</i> Yrs.   | If Under 1 Year<br>Months            | If Under 24 Hrs.<br>Hours  | 8. Date of Birth<br>(Month, Day, Year)<br><i>June 18, 1897</i>                              | 9. Birthplace (State or Foreign Country)<br><i>Maryland</i>                                    |   |   |  |   |
|   | Usual Residence of Decedent   |   |   |                                      |  |   |  |   |   |  |   |
| To Be Completed by Funeral Director   | 10a. State<br><i>Md.</i>  | 10b. County<br><i>Frederick</i>   | 10c. City, Town or Location<br><i>Myersville</i>  |                                      |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |   |  |   |
|   | 10e. Street and Number<br><i>12630 Brandenburg Hollow Rd.</i>   |   |   |                                      | 10f. Zip Code<br><i>21773</i>  |   | 10g. Citizen of What Country?<br><i>U.S.A.</i>   |   |   |  |   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i> |   |  |   |
|   | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>7</i> College (1-4 or 5+)  |   | 16. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><i>Teacher</i>                     |                                      |  |   | 16b. Kind of Business/Industry<br><i>School</i>  |   |   |  |   |
|   | 17. Father's Name (First, Middle, Last)<br><i>Irving Recher Morgan</i>  |   |   |                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Ida Mary Ellen Smith</i>   |   |  |   |   |  |   |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><i>Naomi R. Kuhn (Daughter)</i>   |   |   |                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>12630 Brandenburg Hollow Rd. Myersville, Md. 21773</i>                                   |   |  |   |   |  |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>St. Mark's Lutheran Cemetery</i>                                     |                                      |  |   | 20c. Location - City or Town, State<br><i>Wolfsville, Md.</i>                                  |   |   |  |   |
|   | 21. Signature of Funeral Service Licensee<br><i>James L. Reessler</i>   |   |   |                                      | 22. Name and Address of Facility<br><i>Davis Funeral Home<br/>12525 Bradbury Ave.<br/>Smithsburg, Md. 21783</i>  |   |  |   |   |  |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |                                      |  |   |  |   |   |  | Approximate Interval Between Onset and Death  |
|   | Immediate Cause (Final disease or condition resulting in death)<br>e. <i>DEHYDRATION</i><br>Due to (or as a consequence of):<br>f. <i>ADENOCARCINOMA of COLON METASTATIC</i><br>Due to (or as a consequence of):<br>g. <i>ADENOCARCINOMA of COLON</i><br>Due to (or as a consequence of):<br>h. |   |   |                                      |  |   |  |   |   |  | <i>48 Hours</i><br><br><br><br><br><i>1 YEAR</i><br><br><br><br><br><i>13 YEARS</i> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |                                      |  |   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |
|   |   |   |   |                                      |  |   |  |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |
|   |   |   |   |                                      |  |   |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |                                      |  |   |  |   |   |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |   | 26a. Date of Injury (Month, Day, Year)  |   | 26b. Time of Injury<br>M             |  | 26c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 26d. Describe how injury occurred                                       |   |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><i>James L. Reessler MD</i>  |   | 29c. License number<br><i>D20488</i> |  | 29d. Date signed (Month, Day, Year)<br><i>12/10/97</i>                                      |  |   |   |  |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><i>JAMES L. REESSLER MD PO BOX 17 MIDDLETOWN, MD. 21769</i>   |   |   |   |                                      |  |   |  |   |   |  |   |
| 31. Date filed (Month, Day, Year)<br><i>DEC 15 1997</i>   |   | 32. Registrar's Signature<br><i>John Davidson Randall</i>   |   |                                      |  |   |  |   |   |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

*[Faint handwritten signature]*

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39600

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy Viola

LUBERT

2. Date of Death

December 10 1997

3. Time of Death

1008

4e. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

160-20-6198

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 15, 1926

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Penna.

10b. County

Cambria

10c. City, Town or Location

Barnesboro

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

111 Hickory Street

10f. Zip Code

15714

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
0

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

manager

16b. Kind of Business/Industry

retail store

17. Father's Name (First, Middle, Last)

Fred W. Woods

18. Mother's Name (First, Middle, Maiden Surname)

Bertha L. Ashcraft

19a. Informant's Name/Relationship (Type, Print)

Sharon L. Kellick - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10917 Bayberry Court, Hagerstown, Md. 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

East Ridge Cemetery

Date

12-13-97

20c. Location - City or Town, State

Westover, Pa.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

MINNICH FUNERAL HOME

415 E. Wilson Blvd., Hagerstown, Md. 21740

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute resp. Failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

weeks

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Severe chronic obstructive Pulmonary Disease Years

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 41827

29d. Date signed (Month, Day, Year)

12/11/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. A. Leuchter MD 12821 Oak Hill Ave, Hagerstown MD 21742

31. Date filed (Month, Day, Year)

DEC 12 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

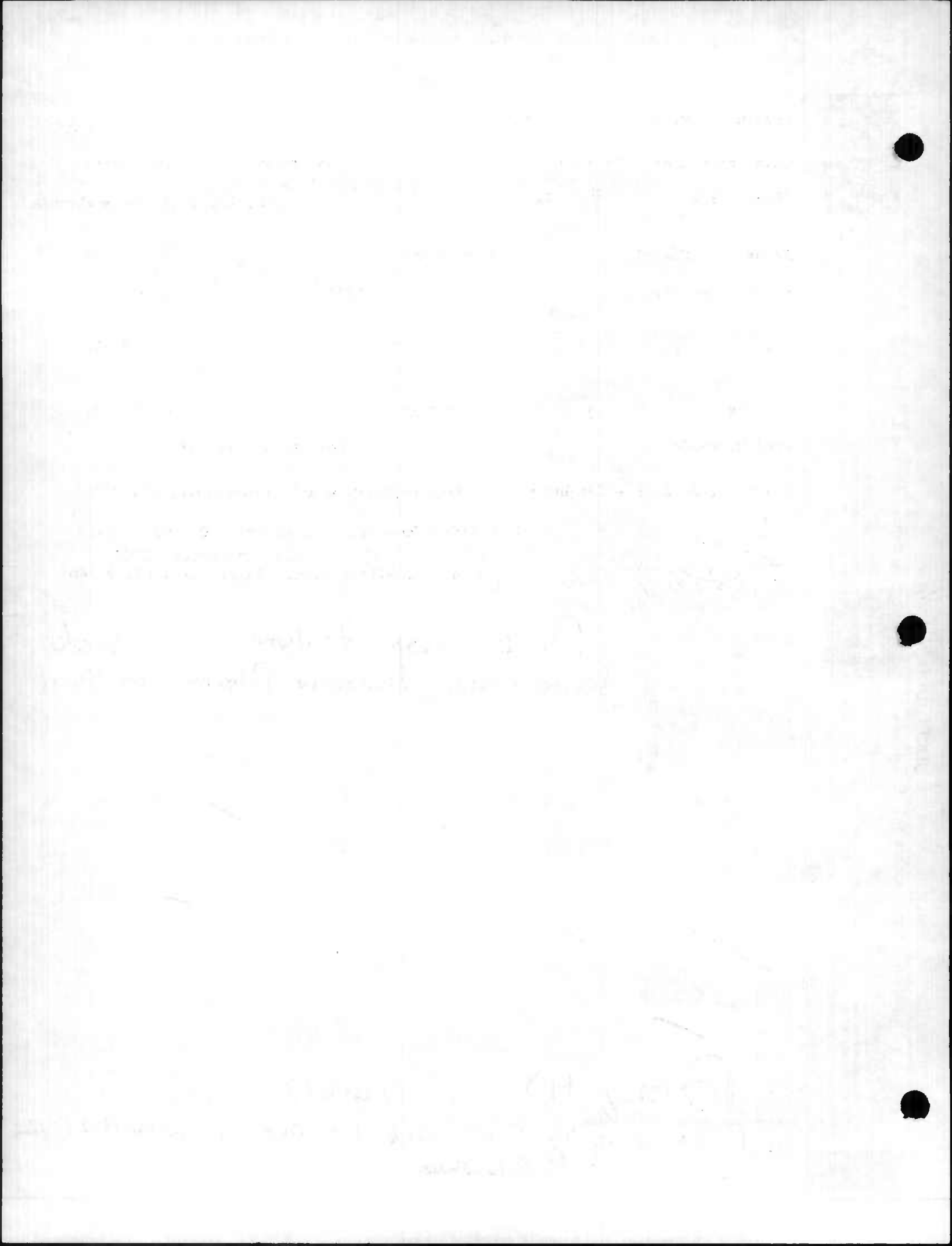
Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39601

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ARTHUR GORE MILLS

2. Date of Death

December 19 1997

3. Time of Death

2:45 pm

4a. Facility Name (If not institution, give street and number)

2528 Toddville Rd.

4b. City, Town, or Location of Death

Toddville

4c. County of Death

Dorchester

Funeral  
Director

5. Social Security Number

214-32-0397

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

63

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 11 1934

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Dorchester

10c. City, Town or Location

Toddville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2528 Toddville Rd.

10f. Zip Code

21672

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No  
If Yes, Give Year or Dates: 1957-63

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

waterman

16b. Kind of Business/Industry

self employed

17. Father's Name (First, Middle, Last)

Preston Winfield

Mills

18. Mother's Name (First, Middle, Maiden Surname)

Sadie

Gore

19a. Informant's Name/Relationship (Type, Print)

Ramona R. Mills - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2528 Toddville Rd., Toddville MD 21672

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans Cemetery 12-22 Hurlock, Maryland

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Kenneth R. Thomas Jr.

22. Name and Address of Facility

Thomas Funeral Home PA 700 Locust St.  
Cambridge MD 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Liver Disease

Due to (or as a consequence of):

b. Colon Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death  
6 months  
2 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Stroke

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Gene Newmier - Physician

29c. License number

H51793

29d. Date signed (Month, Day, Year)

12/22/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gene Newmier, D.O., 503 Byrn Street, Cambridge, Maryland 21613

31. Date filed (Month, Day, Year)

DEC 22 1997

32. Registrar's Signature

Julia Swanson Randall

State  
Registrar

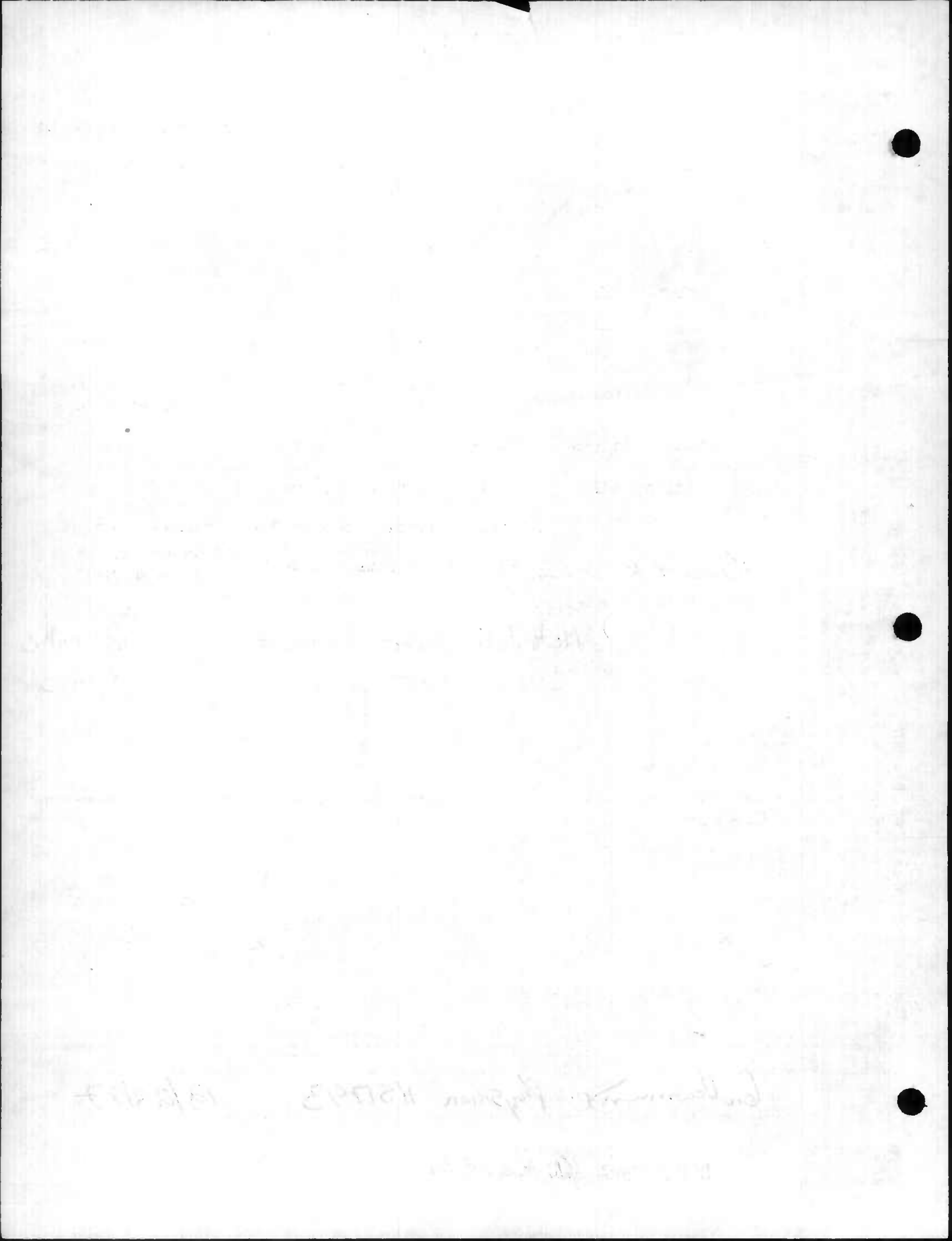
Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39602

|  |  |  |  |  |   |  |   |  |  |  |   |  |
|--|--|--|--|--|---|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Regina Herrmann Murray   |  |  |  |   |  | 2. Date of Death<br>Month Day Year<br>Dec. 7, 1997  |  | 3. Time of Death<br>1820   |  |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Shock Trauma Center  |  |  |  |   |  | 4b. City, Town, or Location of Death<br>Baltimore   |  | 4c. County of Death<br>Baltimore City  |  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br>217-30-3039   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>62 Yrs. |  | 8. Date of Birth (Month, Day, Year)<br>Sept. 8, 1935  |  | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |   |  |
|  | Usual Residence of Decedent  |  |  |  |   |  | 10e. State<br>MD  |  | 10b. County<br>Carroll   |  | 10c. City, Town or Location<br>Sykesville   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |   |  | 10f. Zip Code<br>21784  |  | 10g. Citizen of What Country?<br>U.S.A.  |  |   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |  |  |   |  | 12. Was Decedent Ever In U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)  |  |  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker  |  | 16b. Kind of Business/Industry<br>Domestic   |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br>August Herrmann   |  |  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary Margaret Ganley   |  |  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Mr. John F. Murray (Son)   |  |  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6123 Mantle Road Burke, VA 22015   |  |  |  |   |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Lake View Memorial Park   |  | Date<br>12/12/97   |  | 20c. Location - City or Town, State<br>Sykesville, MD   |  |
|  | 21. Signature of Funeral Service Licensee<br>Brian D. Haight   |  |  |  |   |  | 22. Name and Address of Facility<br>HAIGHT FUNERAL HOME & CHAPEL (Box 195)<br>Sykesville, MD 21784 (410)-795-1400   |  |  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Blunt myocardial injury<br>Due to (or as a consequence of):<br>b. Motor vehicle crash<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d. |  |  |  |   |  | Approximate Interval Between Onset and Death<br>90 min.<br>90 min.  |  |  |  |   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  |  |   |  |
|  |  |  |  |  |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
|  | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  |   |  | 28a. Date of Injury (Month, Day Year)<br>12/7/97  |  | 28b. Time of Injury<br>4:40PM M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|  |  |  |  |  |   |  | 28d. Describe how injury occurred<br>motor vehicle crash  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)<br>Rt. 30 & Fringer Road  |  |   |  |
|  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                |  |  |  |   |  | 29b. Signature and title of certifier<br>William C. Chin, M.D.  |  | 29c. License number<br>D46147  |  | 29d. Date signed (Month, Day, Year)<br>12/7/97  |  |
| State Registrar  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>William Chin, M.D. R. Adams Cowley Shock Trauma Center Baltimore, MD 21201   |  |  |  |   |  | 31. Date filed (Month, Day, Year)<br>DEC 15 1997  |  |  |  |   |  |
|  | 32. Registrar's Signature<br>John A. Davidson-Randall  |  |  |  |   |  |   |  |  |  |   |  |



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39603

|   |  |   |   |  |  |   |   |  |
|---|--|---|---|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Andrew Reed Mauler</b>  |   |   |  | 2. Date of Death<br>Month Day Year<br><b>Dec. 12, 1997</b>   |   | 3. Time of Death<br><b>5:30pm</b>                                       |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>6380 Meadowridge Road</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>Elkridge</b>  |   | 4c. County of Death<br><b>Howard</b>                                    |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-01-1661</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>Feb 27, 1912</b>              |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Howard</b>   |   | 10c. City, Town or Location<br><b>Dayton</b>                            |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br><b>4670 Ten Oaks Road</b>   |  | 10f. Zip Code<br><b>21036</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Plant Superintendant</b>          |  | 16b. Kind of Business/Industry<br><b>Factory</b>   |   |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Andrew Herbert Mauler</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ida Rebecca Myers</b>  |   |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Andrea MacMurray (Daughter)</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4670 Ten Oaks Road Dayton, MD 21036</b>  |   |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Crestlawn Mem. Gardens</b>   |  | 20c. Location - City or Town, State<br><b>12/15/97 Marriottsville, MD</b>  |   |   |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Brian L. Haight</b>  |   |   |  | 22. Name and Address of Facility<br><b>HAIGHT FUNERAL HOME &amp; CHAPEL (Box 195)<br/>Sykesville, MD 21784 (410)-795-1400</b>  |   |   |  |
|   | 23a. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. CONGESTIVE HEART FAILURE</b><br>Due to (or as a consequence of):<br><b>b. SICK SINUS SYNDROME</b><br>Due to (or as a consequence of):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |   |   |  |  |   |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |   |  |  |   |   |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |  |   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |  |  |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>MULTIPLE CEREBRAL INFARCTIONS</b>  |  |   |   |  |  |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
|   |  | 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |  |  |   |   |  |
| 29b. Signature and title of certifier<br><b>Scott Mauler MD</b>   |  | 29c. License number<br><b>D29909</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>DEC. 15, 1997</b>                            |  |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>SCOTT MAULER MD 9501 OLD ANNAPOLIS RD FELLICOTT CITY MD 21042</b>  |  |   |   |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 15 1997</b>   |  | 32. Registrar's Signature<br><b>J. H. Anderson-Randall</b>  |   |  |  |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



State of Maryland / Department of Health and Mental Hygiene

### Certificate of Death

Reg. No.

97 39604

DHMH 16 Rev 6/95

100-100

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39605

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>JUNIOR CARROLL McKINNEY</b>   |  | 2. Date of Death<br>Month Day Year<br><b>DEC. 9, 1997</b>   |   | 3. Time of Death<br><b>7:10 PM.</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>276 E. MAIN ST.</b>   |  |   | 4b. City, Town, or Location of Death<br><b>WESTMINSTER</b>  |  | 4c. County of Death<br><b>CARROLL</b>  |
| 5. Social Security Number<br><b>218-46-4612</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>50</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>4/11/1947</b>  |
| 9. Birthplace (State or Foreign Country)<br><b>WEST VIRGINIA</b>   |  |   |   |  |  |
| 10a. State<br><b>MD.</b>   | 10b. County<br><b>CARROLL</b>  | 10c. City, Town or Location<br><b>WESTMINSTER</b>   |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 10e. Street and Number<br><b>276 E. MAIN St.</b>   |  |   | 10f. Zip Code<br><b>21157</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |   |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>TRUCK DRIVER</b>   |  |   | 18b. Kind of Business/Industry<br><b>TRANSPORTATION</b>   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>ONICO McKINNEY</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>TINA GERTRUDE MOSES</b>   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>JOYCE M. McKINNEY - WIFE</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>276 E. MAIN ST., WESTMINSTER, MD. 21157</b> |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>WESTMINSTER CEM.</b>   |   | 20c. Location - City or Town, State<br><b>12/13/97 WESTMINSTER, MD.</b>  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   | 22. Name and Address of Facility<br><b>FLETCHER FUNERAL HOME</b><br><b>254 E. MAIN ST., WESTMINSTER, MD. 21157</b>                              |  |  |
| 23a. Permit. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. METASTATIC MELANOMA</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |   |  | Approximate Interval Between Onset and Death<br><b>4 mos</b>                                   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  |  |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  |
|  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   | 28d. Describe how Injury occurred  |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |   |  |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D35398</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>12/10/97</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Flavio Kruter, MD 684A Poole Rd - Westminster, MD 21157</b>   |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 11 1997</b>  |  | 32. Registrar's Signature<br>   |   |  |  |

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

97 39606

## Certificate of Death

Reg. No.

|  |  |   |   |  |  |   |  |  |
|--|--|---|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Esterina M. McFiren  |   |   |  | 2. Date of Death<br>Month Day Year<br>Dec 18 1997  |   | 3. Time of Death<br>6:05 AM  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Randolph Hills Nursing Home  |   |   |  | 4b. City, Town, or Location of Death<br>Wheaton  |   | 4c. County of Death<br>Montgomery  |  |
| Funeral<br>Director  | 5. Social Security Number<br>578-01-9093   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>80 Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br>Nov. 14, 1917   |  |
|  | 9. Birthplace (State or Foreign Country)<br>Delaware   |   | 10e. State<br>MD  |  | 10b. County<br>Montgomery  |   | 10c. City, Town or Location<br>Silver Spring   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br>10401 Hayes Avenue  |  | 10f. Zip Code<br>20902   |   | 10g. Citizen of What Country?<br>USA   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever In U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker                                |  | 16b. Kind of Business/Industry<br>Own Home   |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Alfredo Giovacchini   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Rebecca Pasquani  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Thomas J. McFiren (husband)  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>10401 Hayes Avenue, Silver Spring, MD 20902   |   |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Gate of Heaven Cemetery   |  | 20c. Location - City or Town, State<br>Silver Spring, MD   |   | 20d. Date<br>12/20/97  |  |
|  | 21. Signature of Funeral Service Licensee<br>Eric S. Scerbo  |   | 22. Name and Address of Facility<br>Francis J. Collins Funeral Home, Inc. 500 University Blvd. West<br>Silver Spring, MD 20901                        |  |  |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Organic brain disease<br>Due to (or as a consequence of):<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of): |   |   |  |  |   |  |  |
|  | Approximate Interval Between Onset and Death<br>1 year   |   |   |  |  |   |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Hypertensive cardiovascular disease<br>Sepsis, Lower gastrointestinal bleeding   |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |  |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |
| 28d. Describe how Injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>Marian Chung MD  |   | 29c. License number<br>D21615  |  | 29d. Date signed (Month, Day, Year)<br>12-18-97   |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Marian Chung, MD, 3929 Ferrara Dr. Wheaton, MD 20906   |  |   |   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br>DEC 19 1997   |  | 32. Registrar's Signature<br>Julia Davidson-Rendell   |   |  |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39607

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT E. MASON

2. Date of Death

DEC. 11, 1997

3. Time of Death

10:10 PM

4a. Facility Name (If not institution, give street and number)

Prince Georges Hospital

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

PRINCE GEORGES

Funeral  
Director

5. Social Security Number

577-26-5874

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 6, 1906

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

Bladensburg

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4202 58th Avenue

10f. Zip Code

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married

☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Janitor

16b. Kind of Business/Industry

Cleaning Services

17. Father's Name (First, Middle, Last)

Robert Mason

18. Mother's Name (First, Middle, Maiden Surname)

Hyson Braxton

19a. Informant's Name/Relationship (Type, Print)

William Mason (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5701 Westgate Rd., Lanham, MD 20706

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State

☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Md. Nat'l Memorial Pk 12/17/97 Laurel, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*George R. Bracken*

22. Name and Address of Facility

SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Pneumonia*

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

*days*

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *Congestive Heart Failure*

Due to (or as a consequence of):

c. *Congestive Heart Failure*

Due to (or as a consequence of):

*years*

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient

☐ ER/Outpatient

☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural

☐ Accident

☐ Suicide

☐ Homicide

☐ Pending investigation

☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*Surinder Singh*

29c. License number

Maryland D 28920

29d. Date signed (Month, Day, Year)

12/14/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SURINDER SINGH: 7319A Hanover Parkway, Greenbelt, MD, 20770

31. Date filed (Month, Day, Year)

DEC 17 1997

32. Registrar's Signature

*Johia Davidson-Randall*

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ack

Cleaning Ser

Braxton

... Lanham, MD 2070

Original PR 11/17/97

ADEN FUNERAL HOME, P.A.  
ROCKVILLE, MD 20880

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39608

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

William Paul Mason

2. Date of Death

November 30, 1997

3. Time of Death

12:52 AM

4e. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

579-36-3458

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 19 1929

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Takoma Park

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7051 Carroll Avenue #609

10f. Zip Code

20912

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

18a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Construction company

17. Father's Name (First, Middle, Last)

unavailable

18. Mother's Name (First, Middle, Maiden Surname)

Audrey Bowman Douros

19a. Informant's Name/Relationship (Type, Print)

Francis R. Jones/ Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9703 Wyman Way Upper Marlboro, Maryland 20772

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gate of Heaven Cemetery Dec 4 '97 Silver Spring, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home

2222 Wisconsin Ave., N.W. Washington, D.C. 20007

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

6 mos

b. Atrial Fibrillation and Asystole

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

c. Renal Failure

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

Hepatic Hydrothorax

Cirrhosis of the Liver

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Samuel DeShay, M.D.

29c. License number

D19935

29d. Date signed (Month, Day, Year)

November 30, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Samuel DeShay, M.D. 7610 Carroll Ave., #320 Takoma Park, MD 20912

31. Date filed (Month, Day, Year)

DEC 16 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 39609

## Certificate of Death

Reg. No.

|  |  |   |   |                                      |  |  |   |  |  |
|--|--|---|---|--------------------------------------|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Patricia Ola Mathews</b>  |   |   |                                      | 2. Date of Death<br>Month <b>December</b> Day <b>11</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>11:45 PM</b>                                     |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Lorien Nursing and Rehabilitation Columbia</b>  |   |   |                                      | 4b. City, Town, or Location of Death<br><b>Columbia</b>  |  | 4c. County of Death<br><b>Howard</b>                                    |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>225-03-5126</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>89</b> Yrs.  | If Under 1 Year<br>Months            | If Under 24 Hrs.<br>Hours  | 8. Date of Birth<br>(Month, Day, Year)<br><b>August 12, 1908</b>                               | 9. Birthplace (State or Foreign Country)<br><b>Ohio</b>                 |  |  |
|  | Usual Residence of Decedent  |   |   |                                      |  |  |   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Howard</b>  | 10c. City, Town or Location<br><b>Columbia</b>  |                                      |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |  |
|  | 10e. Street and Number<br><b>6334 Cedar Lane</b>   |   |   | 10f. Zip Code<br><b>21044</b>        |  | 10g. Citizen of What Country?<br><b>United States</b>  |   |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>meat packer</b>                |                                      | 16b. Kind of Business/Industry<br><b>Private</b>   |  |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Lewis Pace</b>   |   |   |                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Flora Lena Graybille</b>   |  |   |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Dennis G. Keane/God-Son</b>   |   |   |                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11403 Allview Drive Beltsville Maryland 20705</b>  |  |   |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   |                                      | 20c. Location - City or Town, State<br><b>12-15-97 Alexandria Virginia</b>   |  | 20d. Location - City or Town, State<br><b>Beltsville Maryland</b>       |  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Matthew X Brown</b>  |   |   |                                      | 22. Name and Address of Facility<br><b>Borgwardt Funeral Home</b><br><b>4400 Powder Mill Rd Beltsville Maryland</b>  |  |   |  |  |
|  | 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Pneumonia</b><br>Due to (or as a consequence of):<br><b>b. DEMENTIA</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Multiple cutaneous decubitus ulcers, Peripheral vascular disease, Chronic atrial fibrillation, Coronary artery disease</b> |   |   |                                      |  |  |   | Approximate Interval Between Onset and Death<br><b>7 DAYS</b><br><b>10 YEARS</b>   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Multiple cutaneous decubitus ulcers, Peripheral vascular disease, Chronic atrial fibrillation, Coronary artery disease</b>  |   |   |                                      |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |                                      |  |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |                                      |  |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>      |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |   | 28d. Describe how injury occurred  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>John M</b>  |   | 29c. License number<br><b>D38296</b> |  | 29d. Date signed (Month, Day, Year)<br><b>DEC 12, 1997</b>                                     |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JOSEPH F. GIBBONS, MD 9501 OLD ANNAPOLIS RD, ELICOTT CITY, MD 21042</b>   |  |   |   |                                      |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 18 1997</b>  |  | 32. Registrar's Signature<br><b>John Davidson-Randall</b>   |   |                                      |  |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

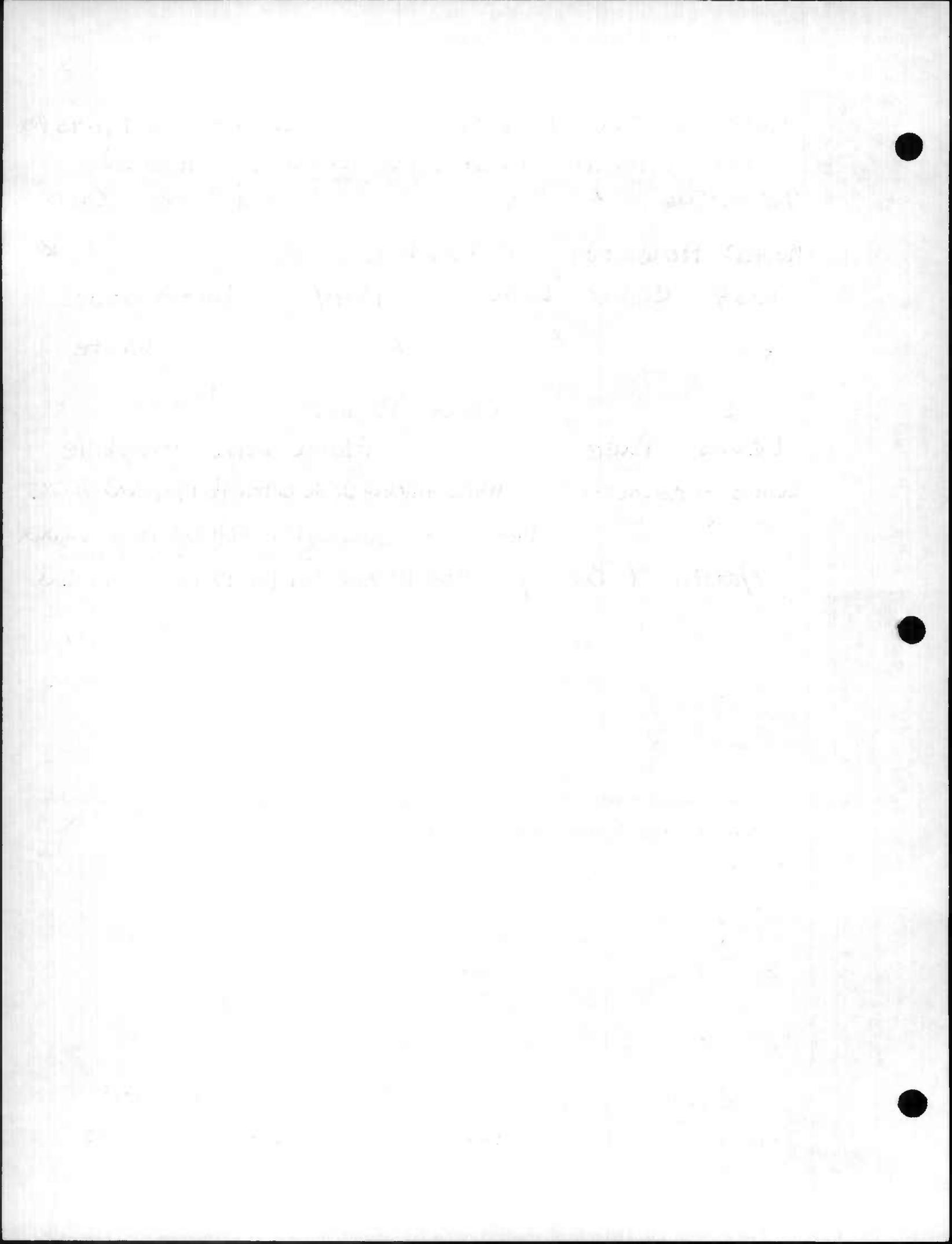
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39610

|  |  |   |   |  |  |  |  |   |  |
|--|--|---|---|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Howard L. McMartin   |   |   |  | 2. Date of Death<br>Month Day Year<br>December 17, 1997  |  | 3. Time of Death<br>4:10 AM                                      |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Manor Care Health Services Chevy Chase   |   |   |  | 4b. City, Town, or Location of Death<br>Chevy Chase  |  | 4c. County of Death<br>Montgomery                                |   |  |
| Funeral<br>Director  | 5. Social Security Number<br>533-36-3484   |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>89 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>February 17, 1908         |   |  |
|  | 9. Birthplace (State or Foreign Country)<br>South Dakota   |   | 10a. State<br>Maryland  |  | 10b. County<br>Montgomery  |  | 10c. City, Town or Location<br>Silver Spring                     |   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br>1316 Fenwick Lane #1405   |  | 10f. Zip Code<br>20910   |  | 10g. Citizen of What Country?<br>United States                   |   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1939-1978 |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 5+  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Physician  |  | 16b. Kind of Business/Industry<br>Public Health Services   |  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br>Frank Clifton McMartin  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Martha Lewis  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br>Paula A. McMartin (Daughter)   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3913 Elby Street, Silver Spring, MD 20906   |  |  |   |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Chesapeake Crematory  |  | 20c. Location - City or Town, State<br>12-18-97 Beltsville, Maryland   |  |  |   |  |
|  | 21. Signature of Funeral Service Licensee<br>  |   | 22. Name and Address of Facility<br>Rapp Funeral Services, P.A.<br>933 Gist Avenue, Silver Spring, MD 20910   |  |  |  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Stroke<br>Due to (or as a consequence of):<br>b. Diabetes Mellitus<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  | Approximate Interval Between Onset and Death<br>2 days<br>years  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Aspiration Pneumonia   |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |   |  |
|  |  |   |   |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how Injury occurred   |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |  |  |  |   |  |
| 29b. Signature and title of certifier<br>  |  |   |   | 29c. License number<br>D 8656  |  | 29d. Date signed (Month, Day, Year)<br>December 17, 1997   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Ravi Passi, M.D., 8609 2nd Avenue Suite #404B, Silver Spring, Maryland 20910   |  |   |   |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br>DEC 18 1997   |  | 32. Registrar's Signature<br>   |   |  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 39611

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth Shelton Morehouse

2. Date of Death

Month Day Year  
December 13, 1997

3. Time of Death

5:58PM

4a. Facility Name (If not institution, give street and number)

1316 Fenwick Lane, #1316

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

213-40-8023

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

96 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 3, 1901

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1316 Fenwick Lane, #1316

10f. Zip Code

20910

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Social Worker

16b. Kind of Business/Industry

Montgomery County  
Juvenile Court

17. Father's Name (First, Middle, Last)

William S. Shelton

18. Mother's Name (First, Middle, Maiden Surname)

Emma Hughes

19a. Informant's Name/Relationship (Type, Print)

William J. Morehouse/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

145 Anton Road, Wynnewood, Pennsylvania 19096

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

December 19, 1997  
Parklawn Memorial Park

Date

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

David E. Perry, MO0803

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/  
Bethesda-Chevy Chase, Inc. 7557 Wisconsin  
Avenue, Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

Approximate Interval Between Onset and Death

6 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Alan J. Diamond

29c. License number

D24245

29d. Date signed (Month, Day, Year)

12/17/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alan J. Diamond, M.D. 10801 Lockwood Drive, #200, Silver Spring, Maryland 20901

31. Date filed (Month, Day, Year)

DEC 18 1997

32. Registrar's Signature

Julia Davidson-Randall

State Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39612

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Michael John Monaghan

2. Date of Death

December 16 1997 0055am

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

577-46-3193

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 27, 1935

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Clarksburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

22515 Schoolfield Court

10f. Zip Code

20871

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 1954-  
195613. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Investigator

16b. Kind of Business/Industry

Motor Vehicle  
Administration

17. Father's Name (First, Middle, Last)

William Joseph Monaghan

18. Mother's Name (First, Middle, Maiden Surname)

Florence Elizabeth McMahon

19a. Informant's Name/Relationship (Type, Print)

Gaye M. Monaghan, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

22515 Schoolfield Court, Clarksburg, MD 20871

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metropolitan Crematory

Date

Dec. 20,  
1997

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Gaye M. Monaghan

22. Name and Address of Facility

DeVol Funeral Home  
10 E. Deer Park Drive, Gaithersburg, MD 2087723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Acute Respiratory failure  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

18 hrs

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Chronic Obstructive Pulmonary Disease  
Due to (or as a consequence of):

Years

c. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Morbid Obesity,  
Probable Sleep apnea, Probable  
Pulmonary Embolus

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John A. Davidson

29c. License number

D22729

29d. Date signed (Month, Day, Year)

December 16, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

John A. Davidson Jr MD 9815 Main St Danvers MD 20877

31. Date filed (Month, Day, Year)

DEC 18 1997

32. Registrar's Signature

John A. Davidson

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39613

Physician  
/Medical  
Examiner

Funeral  
Director

|   |  |   |  |   |                                |   |  |
|---|--|---|--|---|--------------------------------|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Obie Edward Meadows</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>Dec 1, 1997</b>  |                                | 3. Time of Death<br><b>11:06am</b>                                      |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Holy Cross Hospital</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>  |                                | 4c. County of Death<br><b>Montgomery County</b>                         |  |
| 5. Social Security Number<br><b>230-14-4308</b>   |  | 6. Sex<br><b>1</b> M <b>2</b> F   | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>June 4, 1919</b>              |  |
| 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>   |  |   |  |   |                                |   |  |
| 10a. State<br><b>Maryland</b>   |  |   |  | 10b. County<br><b>Montgomery</b>  |                                | 10c. City, Town or Location<br><b>Silver Spring</b>                     |  |
| 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No   |  |   |  |   |                                |   |  |
| 10e. Street and Number<br><b>607 Potomac Avenue</b>   |  |   |  | 10f. Zip Code<br><b>20910</b>   |                                | 10g. Citizen of What Country?<br><b>United States of America</b>        |  |
| 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify:  |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Chef</b>  |                                | 16b. Kind of Business/Industry<br><b>Restaurant</b>                     |  |
| 17. Father's Name (First, Middle, Last)<br><b>Frank H. Meadows</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Nettie Lee Meadows</b>  |                                |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Bertha M. Offenbacher (Sister)</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>607 Potomac Avenue, Silver Spring, Maryland 20910</b>   |                                |   |  |
| 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Beahms Chapel Cemetery</b> |  | Date<br><b>12/5/97</b>  |                                | 20c. Location - City or Town, State<br><b>Luray, Virginia</b>           |  |
| 21. Signature of Funeral Service Licensee #M00690<br><i>Howard A. Carson</i>  |  |   |  | 22. Name and Address of Facility<br><b>The Bradley Funeral Home, Inc.</b><br><b>187 East Main Street, Luray, Virginia</b>   |                                |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |   |                                |   |  |
| Immediate Cause (Final disease or condition resulting in death)   |  |   |  |   |                                |   |  |
| a. <i>Acute myocardial infarction</i> Due to (or as a consequence of): <b>10 minutes</b>  |  |   |  |   |                                |   |  |
| b. <i>Atherosclerotic heart disease</i> Due to (or as a consequence of): <b>10 years</b>  |  |   |  |   |                                |   |  |
| c. <i>Hypertension</i> Due to (or as a consequence of): <b>10 years</b>   |  |   |  |   |                                |   |  |
| d.  |  |   |  |   |                                |   |  |
| 23e. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |                                |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown   |  |   |  |   |                                |   |  |
| 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No  |  |   |  |   |                                |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No   |  |   |  |   |                                |   |  |
| 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) <b>Residence</b> |                                |   |  |
| 27. Manner of Death<br><b>1</b> Natural <b>5</b> Pending Investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |                                | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No                        |  |
| 28d. Describe how injury occurred   |  |   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |                                |   |  |
| 29a. Certifier (Check only one)<br><b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |                                |   |  |
| 29b. Signature and title of certifier<br><i>Alan Weinstock MD</i>   |  |   |  | 29c. License number<br><b>009748 MD</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>12/12/97</b>                  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Alan Weinstock MD 10313 Ga. Ave. #105 Silver Spring Md 20902</b>   |  |   |  |   |                                |   |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 08 1997</b>   |  |   |  | 32. Registrar's Signature<br><i>John Davidson-Randall</i>   |                                |   |  |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39614

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

VIRGINIA MISSOURI

2. Date of Death

DEC. 4 1997

3. Time of Death

3:05 am

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

Funeral  
Director

5. Social Security Number

578-30-1475

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

APRIL 17 1924

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

ODENTON

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

1417 JACKSON ROAD

10f. Zip Code

21113

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Navar Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

DOMESTIC

16b. Kind of Business/Industry

OUT SIDE THE HOME

17. Father's Name (First, Middle, Last)

CHARLES M. FORRESTER

18. Mother's Name (First, Middle, Maiden Surname)

LILLY BELLE

19a. Informant's Name/Relationship (Type, Print)

BARBARA ENNIS (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1417 JACKSON ROAD ODENTON, MD. 21113

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

WILSON CHURCH CEMETERY 12/9/97

20c. Location - City or Town, State

GAMBRILLS

21. Signature of Funeral Service Licensee

Harry R. Reese

22. Name and Address of Facility

WM. REESE &amp; SONS MORTUARY, P.A.

821 WEST ST. ANNAPOLIS, MD. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Heart Failure

Due to (or as a consequence of):

b. CHD

Due to (or as a consequence of):

c. Ess. Hypertension

Due to (or as a consequence of):

d. Carcinoma of lung

Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause (disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

CROFTON Med. Center CROFTON, Md.

29c. License number

MD- D17961

29d. Date signed (Month, Day, Year)

12/8/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CROFTON Med. Center CROFTON, Md.

31. Date filed (Month, Day, Year)

DEC 09 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten text, possibly a date or reference number, including "1942" and "100-100000".

Handwritten signature or name, possibly "J. D. Jones".

Handwritten text at the bottom of the page, possibly a date or reference number, including "1942" and "100-100000".

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 39615

AMEND # 5 12-10-97 cms AACO HEALTH

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Aloysius Gerard McLane

2. Date of Death

Month Day Year  
December 5 1997

3. Time of Death

9:50AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

180 Admiral Cochrane Drive

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

518-28-7923  
578-20-7923

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept 28 1925

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Riva

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

15 Butternut Road

10f. Zip Code

21140

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Administration Officer

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

John McLane

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Carmody

19a. Informant's Name/Relationship (Type, Print)

Naomi Jane McLane (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15 Butternut Road Riva, Maryland 21140

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Ft. Lincoln Crematory 12/8/97

Date

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

John M. Taylor Funeral Home, Inc.  
147 Duke of Gloucester St. Annapolis, MD 2140123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Due to (or as a consequence of)

Approximate  
Interval Between  
Onset and Death

3 months

Sequently list conditions,  
if any, leading to immediate  
cause. Enter underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

{

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D29193

29d. Date signed (Month, Day, Year)

12/05/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen E. Killian MD

31. Date filed (Month, Day, Year)

DEC 10 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

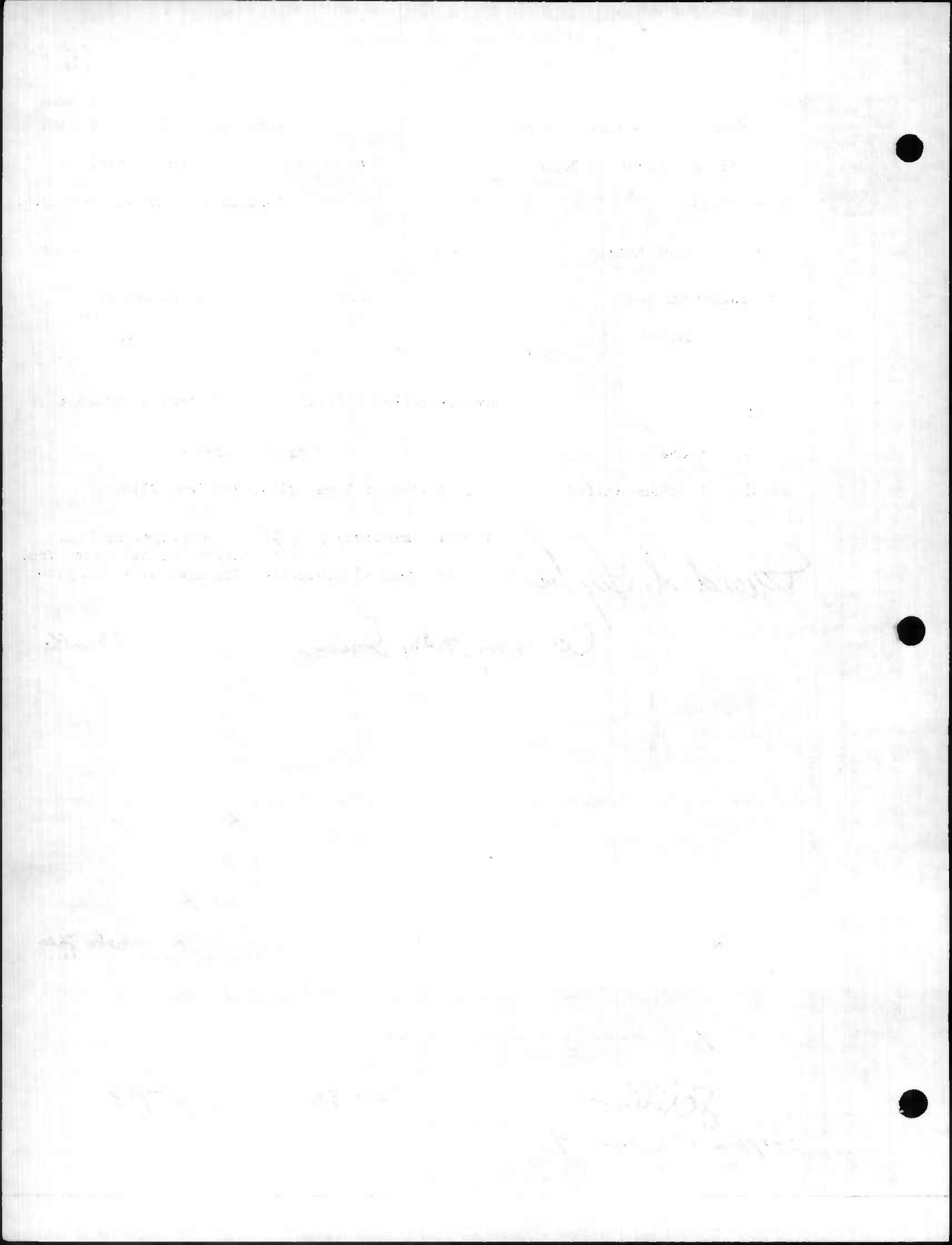
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39616

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Betty Lucille McDonald

2. Date of Death

Month Day Year  
December 07, 1997

3. Time of Death

1145 PM

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

A. A. County

5. Social Security Number

213-26-0951

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan 21, 1931

9. Birthplace (State or Foreign Country)

Washington State

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Severna Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

251 Pertsch Road

10f. Zip Code

21146

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married

3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Arthur Furr

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Painter

19a. Informant's Name/Relationship (Type, Print)

Johnny C. McDonald/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

251 Pertsch Road, Severna Park, MD 21146

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lakemont Cemetery

Date

Dec 11

1997

20c. Location - City or Town, State

Davidsonville, MD

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Barranco & Sons, P.A. Severna Park Funeral Home  
495 Gov. Ritchie Hwy., Severna Park, MD 21146

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CEREBRAL VASCULAR ACCIDENT

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 DAY

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

LARGE VENTRAL HERNIA.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

8 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

4 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

D28221

29d. Date signed (Month, Day, Year)

December 7, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID H. SCHNEIDERMAN, MD NORTH ARUNDEL HOSPITAL

Glen Burnie, MD

31. Date filed (Month, Day, Year)

DEC 11 1997

32. Registrar's Signature

*[Signature]*

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

MCDONALD, Betty L.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 39617

|   |  |  |  |  |  |  |   |  |  |   |  |
|---|--|--|--|--|--|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Clayton Granville MORELAND   |  |  |  |  | 2. Date of Death<br>Month: December Day: 13, Year: 1997  |   | 3. Time of Death<br>8:05 p.m.  |  |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>16956 Shadybrook Terrace   |  |  |  |  | 4b. City, Town, or Location of Death<br>Hagerstown   |   | 4c. County of Death<br>Washington  |  |   |  |
| Funeral<br>Director   | 5. Social Security Number<br>215-38-9481   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br>59 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Feb. 24, 1938  |  | 9. Birthplace (State or Foreign Country)<br>West Virginia        |   |  |
|   | Usual Residence of Decedent  |  |  |  |  | 10. City, Town or Location<br>Hagerstown   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland   |  | 10b. County<br>Washington  |  | 10c. City, Town or Location<br>Hagerstown  |  | 10e. Street and Number<br>16956 Shadybrook Terrace  |  | 10f. Zip Code<br>21740   |   |  |
|   | 10g. Citizen of What Country?<br>U.S.A.  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1955-1959  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: white |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12): 0-12 College (1-4 or 5+): 0  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>truck driver  |  | 16b. Kind of Business/Industry<br>trucking co.   |  | 17. Father's Name (First, Middle, Last)<br>Clayton Franklin Moreland  |  | 18. Mother's Name (First, Middle, Maiden Summa)<br>Roberta May   |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Mrs. Patricia L. Moreland/wife   |  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>16956 Shadybrook Terrace, Hagerstown, Maryland 21740  |   |  |  |   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Cedar Lawn Memorial Park   |  | 20c. Location - City or Town, State<br>Hagerstown, Maryland  |  | 20d. Date<br>Dec. 16, 1997  |  |  |   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  | 22. Name and Address of Facility<br>Minnich Funeral Home<br>415 East Wilson Blvd., Hagerstown, Maryland 21740  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. high grade non-Hodgkin's lymphoma 5 months<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | Approximate Interval Between Onset and Death  |  |  |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>severe coronary artery disease   |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |   |  |  |   |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred                                |   |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><i>[Signature]</i> MD   |  | 29c. License number<br>D46473  |  | 29d. Date signed (Month, Day, Year)<br>12/15/97   |  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Hind Hamdan, MD; 363 S. Cleveland Ave; Hagerstown, MD 21740 |  |  |  |  | 31. Date filed (Month, Day, Year)<br>DEC 15 1997   |  |   |  |  | 32. Registrar's Signature<br><i>[Signature]</i> |  |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39618

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DOROTHY L. MILLER

2. Date of Death

Month Day Year  
12-15-97

3. Time of Death

8:35pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

5219 EASTERN AVE

4b. City, Town, or Location of Death

HYATTSVILLE

4c. County of Death

P.G. COUNTY

5. Social Security Number

579-30-4235

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
APRIL 30, 1908

9. Birthplace (State or Foreign Country)

WASHINGTON DC

Usual Residence of Decedent

10a. State

MD

10b. County

P.G. COUNTY

10c. City, Town or Location

HYATTSVILLE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

5219 EASTERN AVE

10f. Zip Code

20782

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ELEVATOR OPERATOR

16b. Kind of Business/Industry

GOVERNMENT

17. Father's Name (First, Middle, Last)

FRANK LEWIS

18. Mother's Name (First, Middle, Maiden Surname)

ROSIE LEWIS

19a. Informant's Name/Relationship (Type, Print)

ADOLPHUS PRICE /SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4919 4th ST N.W. WASHINGTON DC 20011

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HARMONY MEMORIAL PARK

Date

12-19-97

20c. Location - City or Town, State

LANDOVER MD

21. Signature of Funeral Service Licensee

Alexander S. Pope Jr

22. Name and Address of Facility

ALEXANDER S. POPE FUNERAL HOMES  
2617 PENN. AVE S.E. WASHINGTON DC 20020

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC CANCER  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 month

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. COLON CANCER

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Uma Prasad MD

29c. License number

DC 17310

29d. Date signed (Month, Day, Year)

12/16/97

30. Name and address of person who completed causa of death (item 23a) (Type, Print)

UMA PRASAD M.D.  
2100 W. PENNSYLVANIA AVE, N.W. D.C. 20037

31. Date filed (Month, Day, Year)

DEC 19 1997

32. Registrar's Signature

John A. R. R. R.

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

7



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39619

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Louise McNeill

2. Date of Death

Month Dec. 5, Day 1997 Year

3. Time of Death

2:30AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Fox Chase Rehabilitation &amp; Nursing Ctr SilverSp.Md. Montgomery County

4b. City, Town, or Location of Death

4c. County of Death

5. Social Security Number

712-10-0115

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Feb. 18, 1922 No. Carolina

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

DC

10b. County

None

10c. City, Town or Location

Washington, DC

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1427 Holbrook Street, N. E.

10f. Zip Code

20003

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Construction

16b. Kind of Business/Industry

Private Industry

17. Father's Name (First, Middle, Last)

William Simpson

18. Mother's Name (First, Middle, Maiden Surname)

Mary Edwards

19a. Informant's Name/Relationship (Type, Print)

Barbara Gilliard (DAUGHTER) 286 Miracle Dr., Eutawville, So. Carolina

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Forest Hill Cemetery Dec. 11, 1997 Clinton, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ralph Williams

22. Name and Address of Facility

Ralph Williams Funeral Service

517 - 11th Street, S.E.; Wash., DC

Physician  
/Medical  
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

STROKE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 day

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

CHRONIC RENAL FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Medical Examiner2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ralph Williams

29c. License number

D 28656

29d. Date signed (Month, Day, Year)

DECEMBER 8, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ravi Passi MD. 8609 SECOND AVENUE #404B, S. SPRING, MD 20910

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 15 1997

32. Registrar's Signature

Ravi Passi

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

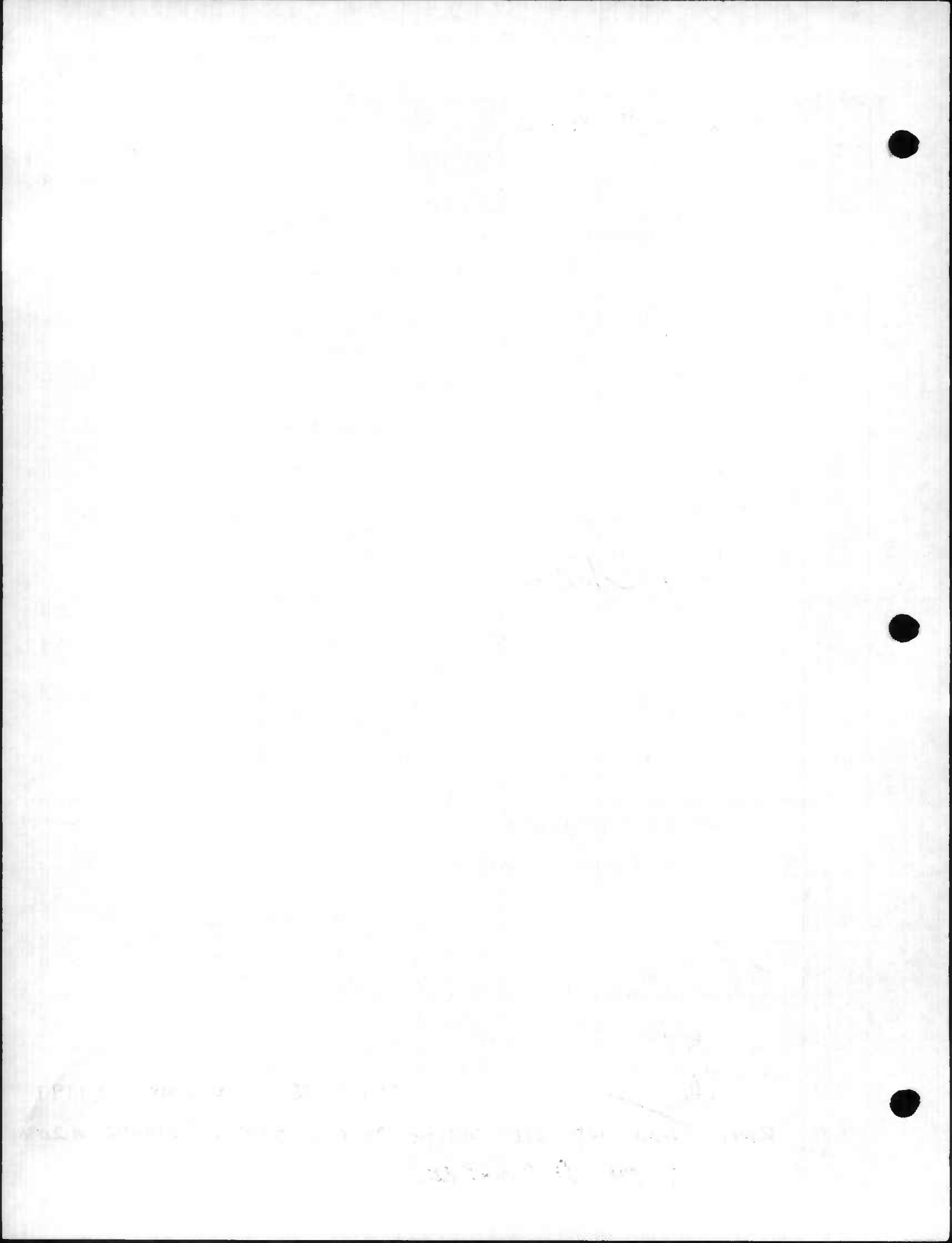
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39620

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LEWIS HENRY MORRIS

2. Date of Death

DEC. 9, 1997

3. Time of Death

7:35 PM

4a. Facility Name (If not institution, give street and number)

NATIONAL LUTHERAN HOME

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY CO.

Funeral  
Director

5. Social Security Number

235-01-1784

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84

8. Date of Birth (Month, Day, Year)

APR. 22, 1913

9. Birthplace (State or Foreign Country)

WEST VA.

Usual Residence of Decedent

10a. State

WEST VA. KANAWHA CO.

10b. County

10c. City, Town or Location

DUNBAR

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

505-CLADWELL 505 CALDWELL

10f. Zip Code

25064

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates

UNKNOWN

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

INSTRUMENT ENGINEER

16b. Kind of Business/Industry

UNION CARBIDE CO.

17. Father's Name (First, Middle, Last)

JAMES MORRIS JAMES MORRIS

18. Mother's Name (First, Middle, Maiden Surname)

THURSDA MAE HARLESS

19a. Informant's Name/Relationship (Type, Print)

DAVID A. MORRIS- SON

19b. Mailing Address (Street and Number, City or Town, State, Zip Code)

17612-BOWIE MILL RD., DERWOOD, MD. 20855

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SPRING HILL CEMETERY

Data

12/13

20c. Location - City or Town, State

CHARLESTON, W.VA.

21. Signature of Funeral Service Licensee

W. M. Morris

22. Name and Address of Facility

HYSONG CO., INC.

1300- N STREET, NW, WASH., DC

23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

pulmonary edema  
Due to (or as a consequence of):  
Congestive heart failure  
Due to (or as a consequence of):  
Acute renal failure  
Due to (or as a consequence of):  
Chronic Obstructive Pulmonary Disease

Approximate Interval Between Onset and Death

7 days

3 months

2 weeks

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

atrial Fibrillation  
Coronary artery disease

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural5 ☐ Pending Investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Charles W. Karesch

29c. License number

D21726

29d. Date signed (Month, Day, Year)

December 10, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. CHARLES W. KARESCH- 9701- VEIRS DR., ROCKVILLE, MD.

31. Date filed (Month, Day, Year)

DEC 15 1997

32. Registrar's Signature

John A. Karesch

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

14-10-1911

Received of Mr. J. H. ...  
the sum of ...  
for ...  
£ ...

Witness my hand and seal this ... day of ... 1911  
J. H. ...  
1911

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39621

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>JESSE LINDSAY MITCHELL, JR.</b>   |  |   |  | 2. Date of Death<br>Month <b>DECEMBER</b> Day <b>12</b> , Year <b>1997</b>  |  | 3. Time of Death<br><b>3:15AM</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>P. G. GENERAL HOSPITAL</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>CHEVERLY</b>   |  | 4c. County of Death<br><b>PRINCE GEORGES</b>  |  |
| 5. Social Security Number<br><b>578-13-6245</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>19</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>JULY 31, 1978</b>                                 |  |
| 9. Birthplace (State or Foreign Country)<br><b>WASH. D.C.</b>  |  | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>PRINCE GEORGES</b>  |  | 10c. City, Town or Location<br><b>LANDOVER</b>  |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>6910 FOREST TERRACE</b>  |  | 10f. Zip Code<br><b>20785</b>   |  | 10g. Citizen of What Country?<br><b>UNITED STATES</b>                                       |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                     |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12TH</b> College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>FOOD CLERK</b>  |  | 16b. Kind of Business/Industry<br><b>SHOPPERS FOOD WAREHOUSE</b>  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>JESSE MITCHELL, SR.</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>SHAREN L. THOMAS MITCHELL</b>   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>SHAREN L. MITCHELL/MOTHER</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6910 FOREST TERRACE, LANDOVER, MD 20785</b>   |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>WASHINGTON NAT. CEMETERY</b>   |  | 20c. Location - City or Town, State<br><b>12-17-97 SUITLAND, MARYLAND</b>   |  |   |  |
| 21. Signature of Funeral Service Licensee<br><br><b>EDWARD M. DUDLEY</b>   |  | 22. Name and Address of Facility<br><b>DUDLEY FUNERAL HOME</b><br><b>3200 RHODE ISLAND AVE., MT. RAINIER, MD 20712</b>  |  |   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Multiple Gunshot Wounds</b><br>Due to (or as a consequence of):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |  |   |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |   |  |   |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |   |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |   |  |   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)<br><b>12/12/97</b>  |  | 28b. Time of Injury<br><b>0255 M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 28d. Describe how injury occurred<br><b>Subject's Lot</b>  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>STREET</b>   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>6893 Forest Terrace 20785</b>  |  |   |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br><br><b>J. Aaron Lake, MD</b>  |  | 29c. License number<br><b>O.C.M.E.</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>DECEMBER 12, 1997</b>                             |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>J. Aaron Lake, MD 111 Penn Street, Baltimore, Maryland 21201</b>  |  |   |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 17 1997</b>  |  | 32. Registrar's Signature<br>  |  |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar

Shirley Baker 2/11/11

X

X

X

Table 1 - 1950

Table 2 - 1950

Table 3 - 1950

Table 4 - 1950

Continued on next page

See also Table 5

Continued on next page

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WALTER M. MILES

2. Date of Death  
Month Day Year

DECEMBER 14, 1997

3. Time of Death

8:25 AM

4a. Facility Name (If not institution, give street and number)

MONTGOMERY GENERAL HOSPITAL

4b. City, Town, or Location of Death

OLNEY

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

577-24-2801

6. Sex  
☒ M ☐ F

7. Age (In yrs. last birthday)

72

If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.6. Date of Birth  
(Month, Day, Year)

December 23, 1924 WASHINGTON D.C.

9. Birthplace (State or Foreign  
Country)

Usual Residence of Decedent

10a. State

MARYLAND MONTGOMERY

10b. County

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2602 SQUAW VALLEY CT. #1

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?☒ Yes ☐ NoIf Yes, Give  
Year or Dates 6-15-43  
3-6-4613. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

LANDSCAPER

16b. Kind of Business/Industry

PRIVATE

17. Father's Name (First, Middle, Last)

UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname)

AGNES MILES

19a. Informant's Name/Relationship (Type, Print)

DEBORAH CHANDLER/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9117 6th STREET LANHAM, MD 20706

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

WASHINGTON NATIONAL CEM

Date

12-18

20c. Location - City or Town, State

SUITLAND, MARYLAND

21. Signature of Funeral Service Licensee

Amberley C. Buscoe-Tomlin

22. Name and Address of Facility

MARSHALL'S FUNERAL HOME

4308 SUITLAND ROAD SUITLAND, MD 20746

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

PNEUMONIA

Approximate  
Interval Between  
Onset and Death

10 days

e. Due to (or as a consequence of):  
DEHYDRATION

2 weeks

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

28. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending  
Investigation☐ Could not be  
determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D25974

29d. Date signed (Month, Day, Year)

DECEMBER 15, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Evelyn Jackson, MD 18101 PRINCE PHILLIP DR. OLNEY, MD 20832

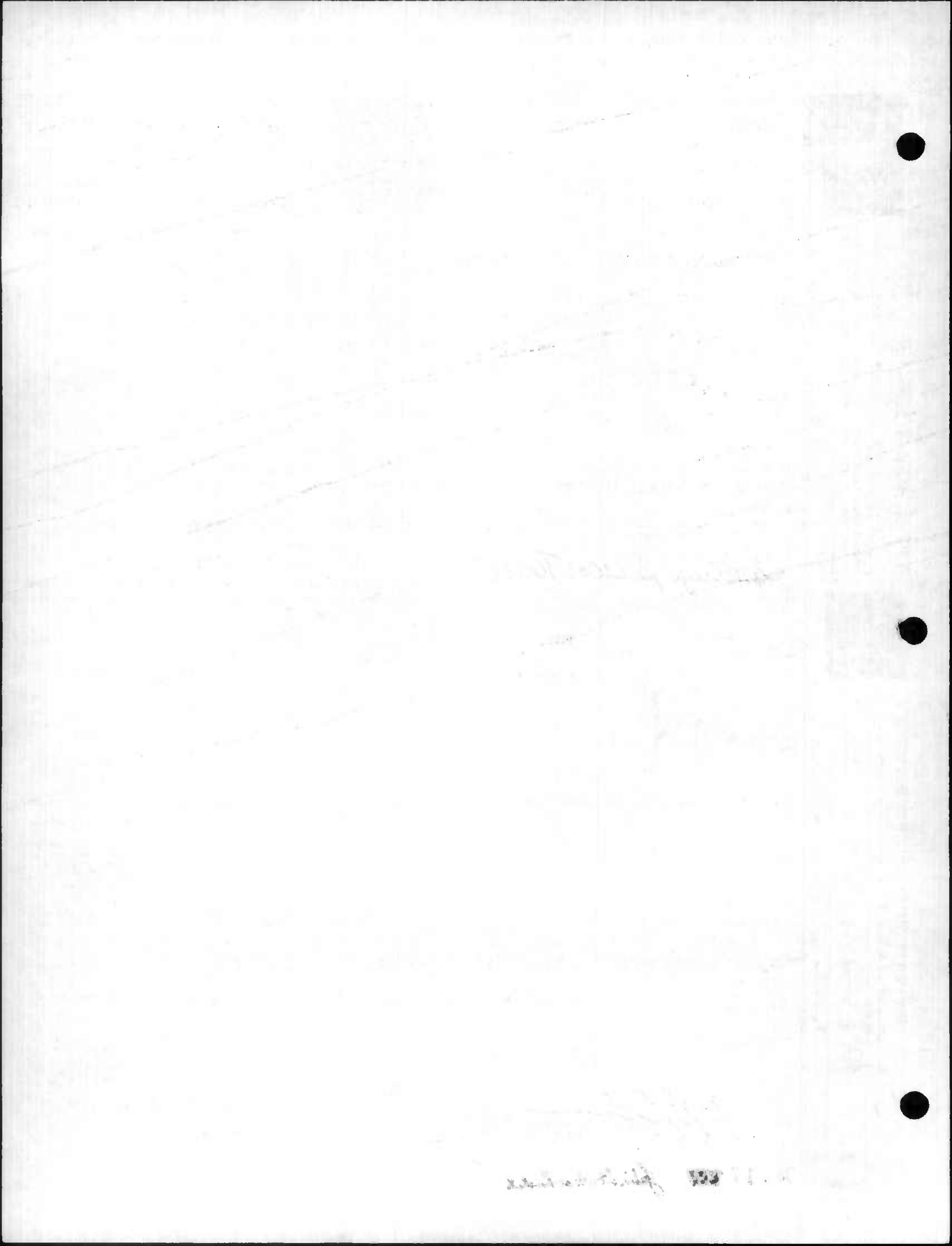
31. Date filed (Month, Day, Year)

DEC 17 1997

32. Registrar's Signature

John D. ...

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

87 39623

|  |   |   |  |  |   |  |  |  |
|--|---|---|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>ROBERT CHARLES MARTIN</b>                |   |  |  | 2. Date of Death<br>Month Day Year<br><b>DEC. 17 1997</b> |  | 3. Time of Death<br><b>9:10 AM</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Franklin Woods</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  | 4c. County of Death<br><b>Baltimore</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>096-32-2797</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>56</b> Yrs.   | If Under 1 Year<br>Months Days                            | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 30, 1941</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>New York</b>    |
|  | Usual Residence of Decedent   |   |  |  |   |  |  |  |
| 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Harford</b>   |  | 10c. City, Town or Location<br><b>Edgewood</b>   |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>327 McCann Street</b>   |   |   |  | 10f. Zip Code<br><b>21040</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>UNK</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Highway Maintenance</b>  |   |  | 16b. Kind of Business/Industry<br><b>County Government</b>                                     |  |
| 17. Father's Name (First, Middle, Last)<br><b>John Jack Martin</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Stephanie Blanch Cox</b>   |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Darcus J. Martin/ Wife</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>327 McCann Street, Edgewood, MD 21040</b>  |   |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hilltop Crematory</b>  |  | Date<br><b>12-17-97</b>  |   | 20c. Location - City or Town, State<br><b>Towson, Maryland</b>   |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Charles A. Emge Jr.</i>  |   |   |  | 22. Name and Address of Facility<br><b>Howard K. Mc Comas III Funeral Home, P.A.<br/>1317 Cokesbury Rd., Abingdon, MD 21009</b>  |   |  |  |  |
| 23a. Pert I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Respiratory Failure</b><br>Due to (or as a consequence of):<br>b. <b>Lung Cancer</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |   |   |  |  |   |  |  | Approximate Interval Between Onset and Death<br><b>Unknown</b> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
|  |   |   |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |
|  |   |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how Injury occurred                              |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |  |  |   |  |  |  |
| 29b. Signature and title of certifier<br><i>Dr. Ralapati M.D.</i>  |   |   |  | 29c. License number<br><b>2050757</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>12-17-97</b>   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Anuradha Ralapati 9105 Franklin Square Drive, Baltimore, Maryland 21237</b>   |   |   |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 19 1997</b>  |   |   |  | 32. Registrar's Signature<br><i>John A. ...</i>  |   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39624

|   |   |   |   |                                       |  |  |   |   |  |
|---|---|---|---|---------------------------------------|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Bruce Francis Milanoski</b>  |   |   |                                       | 2. Date of Death<br>Month Day Year<br><b>DEC. 13, 1997</b>   |  | 3. Time of Death<br><b>1438 PM</b>                                      |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>CHURCH HOME HOSPITAL E.R.</b>  |   |   |                                       | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death   |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>212-48-5885</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>51</b> Yrs.  | If Under 1 Year<br>Months Days        | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 23, 1946</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |
|   | Usual Residence of Decedent   |   |   |                                       |  |  |   |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Harford</b>   | 10c. City, Town or Location<br><b>Bel Air</b>   |                                       |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |
|   | 10e. Street and Number<br><b>501 Plumtree Road</b>  |   |   | 10f. Zip Code<br><b>21015</b>         |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever In U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1965/69</b> |                                       | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> Collage (1-4or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Accountant</b>                            |                                       | 16b. Kind of Business/Industry<br><b>Accounting</b>  |  |   |   |  |
| To Be Completed by Physician/Medical Examiner   | 17. Father's Name (First, Middle, Last)<br><b>Francis Anthony Milanoski</b>   |   |   |                                       | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Corella Irene Miller</b>   |  |   |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Marie Milanoski</b>  |   |   |                                       | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>501 Plumtree Road, Bel Air, MD 21015</b>   |  |   |   |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hilltop Service Corp.</b>  |                                       | 20c. Location - City or Town, State<br><b>12-17-97 Towson, Maryland</b>  |  |   |   |  |
|   | 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br><b>Howard K. McComas III Funeral Home, P.A.<br/>1317 Cokesbury RD, Abingdon, MD 21009</b>                             |                                       |  |  |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Arteriosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |   |   |   |                                       |  |  |   | Approximate Interval Between Onset and Death  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |                                       |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |   |  |
|   |   |   |   |                                       |  | 24a. Was an autopsy performed?<br><b>INSPECTION</b><br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |                                       |  |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accidental 6 <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicidal 4 <input type="checkbox"/> Homicidal   |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>       |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 28d. Describe how injury occurred   |  |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |                                       |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |   |   |                                       |  |  |   |   |  |
| 29b. Signature and title of certifier<br>   |   |   |   | 29c. License number<br><b>O.C.M.E</b> |  | 29d. Date signed (Month, Day, Year)<br><b>DEC. 13, 1997</b>  |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Donald G. Wright M.D. 111 Penn Street, Baltimore, Maryland 21201</b>   |   |   |   |                                       |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 17 1997</b>   |   | 32. Registrar's Signature<br>   |   |                                       |  |  |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39625

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Karnig (nm) Mooshian

2. Date of Death  
Month Day Year

December 16, 1997

3. Time of Death  
2:15 AM

4a. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

039-09-7168

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

Feb. 5, 1916

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Abingdon

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

401 Autumn Leaf Ct.

10f. Zip Code

21009

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

1940

1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify:

White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Technical Writer

16b. Kind of Business/Industry

Defense Manufacturing

17. Father's Name (First, Middle, Last)

Assadoor George Mooshian

18. Mother's Name (First, Middle, Maiden Surname)

Schnorhoon Grace Boghosian

19a. Informant's Name/Relationship (Type, Print)

Alta L. Martin - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

401 Autumn Leaf Ct., Abingdon, Maryland 21009

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mt. Zion Cemetery

Date

12-19-97

20c. Location - City or Town, State

Bel Air, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Howard K. McComas III Funeral Home, P.A.

1317 Cokesbury Road, Abingdon, MD 21009

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a.

PANGLOSSIA

Due to (or as a consequence of):

b.

bone marrow FAILURE

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

1 WEEK

1 WEEK

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RHEUMATOID ARTHRITIS

SEPSIS

HERPES ZOSTER

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D31775

29d. Date signed (Month, Day, Year)

DECEMBER 16, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John P. Edwards, MD.

2112 BELAIR ROAD

FALLSTON, MARYLAND 21047

31. Date filed (Month, Day, Year)

DEC 17 1997

32. Registrar's Signature

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 39626

## Certificate of Death

Reg. No.

|   |   |                  |   |  |  |  |   |  |   |   |  |  |                 |          |  |          |  |
|---|---|------------------|---|--|--|--|---|--|---|---|--|--|-----------------|----------|--|----------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><i>Donna G. MILLER</i>  |                  |   |  | 2. Date of Death<br>Month Day Year<br><i>DECEMBER 3, 1997</i>  |  | 3. Time of Death<br><i>19:34p</i>                                       |  |   |   |  |  |                 |          |  |          |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><i>THE JOHNS HOPKINS HOSPITAL</i>   |                  |   |  | 4b. City, Town, or Location of Death<br><i>BALTIMORE CITY</i>  |  | 4c. County of Death<br><i>Baltimore</i>                                 |  |   |   |  |  |                 |          |  |          |  |
| Funeral<br>Director   | 5. Social Security Number<br><i>216-38-0245</i>   |                  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><i>54</i> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><i>Dec. 25 1942</i>              |  |   |   |  |  |                 |          |  |          |  |
|   | 9. Birthplace (State or Foreign Country)<br><i>Maryland</i>   |                  | 10a. State<br><i>Maryland</i>   |  | 10b. County<br><i>Anne Arundel</i>   |  | 10c. City, Town or Location<br><i>Glen Burnie</i>                       |  |   |   |  |  |                 |          |  |          |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |                  | 10e. Street and Number<br><i>128 Bonnie View Road</i>   |  | 10f. Zip Code<br><i>21060</i>  |  | 10g. Citizen of What Country?<br><i>U.S.A.</i>                          |  |   |   |  |  |                 |          |  |          |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |                  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i> |  |   |   |  |  |                 |          |  |          |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>0-12</i> College (1-4 or 5+) <i></i>  |                  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Sales Clerk</i>                   |  | 16b. Kind of Business/Industry<br><i>Retail</i>  |  |   |  |   |   |  |  |                 |          |  |          |  |
|   | 17. Father's Name (First, Middle, Last)<br><i>Emil Cox</i>  |                  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Fern Mogensen</i>  |  |   |  |   |   |  |  |                 |          |  |          |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><i>Jay M. Miller - Husband</i>  |                  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>128 Bonnie View Road Glen Burnie, Md. 21060</i>  |  |   |  |   |   |  |  |                 |          |  |          |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |                  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Greenlawn Memorial Park 12-8-97 Williamsport, Md.</i>                |  | 20c. Location - City or Town, State  |  |   |  |   |   |  |  |                 |          |  |          |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Fred L. West</i>  |                  |   |  | 22. Name and Address of Facility<br><i>Minnich Funeral Home<br/>415 E. Wilson Blvd. Hagerstown, Md. 21740</i>  |  |   |  |   |   |  |  |                 |          |  |          |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |                  |   |  |  |  |   |  |   |   |  |  |                 |          |  |          |  |
|   | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <i>Sepsis</i></td> <td>Approximate Interval Between Onset and Death<br/><i>1 week</i></td> </tr> <tr> <td>b. <i>metastatic pancreatic cancer</i></td> <td><i>5 months</i></td> </tr> <tr> <td>c. _____</td> <td></td> </tr> <tr> <td>d. _____</td> <td></td> </tr> </table> |                  |   |  |  |  |   |  | Immediate Cause (Final disease or condition resulting in death) | a. <i>Sepsis</i>  | Approximate Interval Between Onset and Death<br><i>1 week</i>  | b. <i>metastatic pancreatic cancer</i> | <i>5 months</i> | c. _____ |  | d. _____ |  |
|   | Immediate Cause (Final disease or condition resulting in death)   | a. <i>Sepsis</i> | Approximate Interval Between Onset and Death<br><i>1 week</i>   |  |  |  |   |  |   |   |  |  |                 |          |  |          |  |
| b. <i>metastatic pancreatic cancer</i>  |   | <i>5 months</i>  |   |  |  |  |   |  |   |   |  |  |                 |          |  |          |  |
| c. _____  |   |                  |   |  |  |  |   |  |   |   |  |  |                 |          |  |          |  |
| d. _____  |   |                  |   |  |  |  |   |  |   |   |  |  |                 |          |  |          |  |
| <table border="1"> <tr> <td colspan="2">23b. Did tobacco use contribute to the cause of death?<br/><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown</td> </tr> <tr> <td>24a. Was an autopsy performed?<br/><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> <td>24b. Were autopsy findings available prior to completion of cause of death?<br/><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> </tr> </table> |   |                  |   |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |                 |          |  |          |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |                  |   |  |  |  |   |  |   |   |  |  |                 |          |  |          |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                  |   |  |  |  |   |  |   |   |  |  |                 |          |  |          |  |

| Physician /Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. *Trousseau's Syndrome* *Gastrointestinal hemorrhage* *Perforated duodenal ulcer* | | | |  | | | |
| 25. Was case referred to medical examiner? ☐ Yes ☒ No | | | | 26. Place of Death (Check only one) Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify) | | | |
| 27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined | | 28a. Date of Injury (Month, Day Year) | | 28b. Time of Injury M | | 28c. Injury at Work? ☐ Yes ☒ No | |
| 28d. Describe how injury occurred | | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | |  |
| 29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | |
| State Registrar | 29b. Signature and title of certifier *Charles C. Della Santina MD PhD* | | | | 29c. License number *RES-000* | | 29d. Date signed (Month, Day, Year) *12/3/97* | |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) *Charles C. Della Santina MD PhD; Johns Hopkins Hosp. 600 North St Baltimore MD 21287* | | | | | | | |
| 31. Date filed (Month, Day, Year) *DEC 11 1997* | | | | 32. Registered *J. A. Davidson* | | | |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39627

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JANET McFERREN

2. Date of Death

DEC

Day

09

Year

97

3. Time of Death

7:35am

Funeral  
Director

4e. Facility Name (If not institution, give street and number)

UNIVERSITY OF MARYLAND Hospital

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

5. Social Security Number

186-30-6594

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

59 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MAR 5, 1938

9. Birthplace (State or Foreign Country)

PATTON PA

Usual Residence of Decedent

10a. State

PA

10b. County

FRANKLIN

10c. City, Town or Location

CHAMBERSBURG

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

521 WEAVER AVE.

10f. Zip Code

17201

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
1 2

College (1-4 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

ALBERT R. THOMAS

18. Mother's Name (First, Middle, Maiden Surname)

RUTH BAERER

19a. Informant's Name/Relationship (Type, Print)

GEORGE W. McFERREN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

521 WEAVER AVE. CHAMBG. PA 17201

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

PARKLAWNS MEM. GARDENS

Date

12-12-97

20c. Location - City or Town, State

CHAMBG. PA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

297 PHILA. AVE.  
R.G. SELLERS F.H. CHAMBERSBURG, PA 17201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

PROBABLE MYOCARDIAL EVENT VERSUS STROKE

Due to (or as a consequence of):

END STAGE RENAL DISEASE

Due to (or as a consequence of):

SPICADAVEINIC RENAL TRANSPLANT

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate interval between Onset and Death  
LESS than 1HR AND 35min

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D40130

29d. Date signed (Month, Day, Year)

DEC. 11, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

CYNTHIA DRACHENBERG 22 South GREENE ST. Balto., MD 21201

31. Date filed (Month, Day, Year)

DEC 12 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39628

|  |  |                                  |   |   |  |  |   |  |  |  |
|--|--|----------------------------------|---|---|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Virginia Willis Mowery</b>                          |                                  |   |   |  |  | 2. Date of Death<br>Month Day Year<br><b>Dec. 12, 1997</b>                                  |  | 3. Time of Death<br><b>6:40 A. M.</b>                            |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Colton Villa Nursing Home</b> |                                  |   |   |  |  | 4b. City, Town, or Location of Death<br><b>Hagerstown</b>                                   |  | 4c. County of Death<br><b>Washington</b>                         |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>214-28-6094</b>  |                                  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (in yrs. last birthday)<br><b>80</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>July 4, 1917</b>                                  |  | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b> |  |
|  | Usual Residence of Decedent  |                                  |   |   |  |  |   |  |  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Washington</b> |   | 10c. City, Town or Location<br><b>Hagerstown</b>  |  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| 10e. Street and Number<br><b>213 Norway Avenue</b>   |  |                                  |   | 10f. Zip Code<br><b>21740</b>   |  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |                                  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+)   |  |                                  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>homemaker</b> |  |  | 16b. Kind of Business/Industry<br><b>home</b>   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>George William Shook</b>   |  |                                  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Essy W. Feaster</b>  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Brenda M. Wilson</b>  |  |                                  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>213 Norway Avenue Hagerstown, Maryland 21740</b> |   |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |                                  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Rest Haven Cemetery</b>  |   |  | 20c. Location - City or Town, State<br><b>12/16/97 Hagerstown, Maryland</b>  |   | Approximate Interval Between Onset and Death   |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Gerald N. Minnich</i>  |  |                                  |   |   |  | 22. Name and Address of Facility<br><b>Gerald N. Minnich 305 N. Potomac Street Hagerstown, Maryland 21740</b>  |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Cerebrovascular accident</b><br>Due to (or as a consequence of):<br><b>b. HSCVD</b><br>Due to (or as a consequence of):<br><b>c. DM Type II</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |                                  |   |   |  |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |                                  |   |   |  |  |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |                                  |   |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |  |
|  |  |                                  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                                  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  |                                  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred                                |  |
|  |  |                                  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |                                  | 29b. Signature and title of certifier<br><i>[Signature]</i>   |   |  | 29c. License number<br><b>DH431</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>12/12/97</b>   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JERRY L. CORRECES, M.D.</b>   |  |                                  |   |   |  | <b>338 MILL ST. HAGERSTOWN MD 21740</b>  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 15 1997</b>  |  |                                  | 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |  |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 39629

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth Anna Mason

2. Date of Death

Month Day Year  
Dec. 11, 1997

3. Time of Death

1:44 PM

4a. Facility Name (If not institution, give street and number)

3006 Geaton Drive

4b. City, Town, or Location of Death

Upper Marlboro

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

579-42-5890

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

64

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 8, 1933

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Forestville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2616 Lakehurst Avenue

10f. Zip Code

20747

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Hairdresser

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Edward Chandler Staples

18. Mother's Name (First, Middle, Maiden Surname)

Mary E. Wells

19a. Informant's Name/Relationship (Type, Print)

Chris Hackett, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3006 Ritchie Marlboro Road, Upper Marlboro, MD 20772

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Fort Lincoln Cemetery

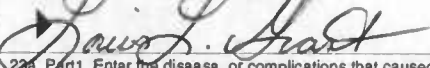
Date

12/15/97

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Fort Lincoln Funeral Home

3401 Bladensburg Rd., Brentwood, Maryland 20722

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Metastatic Lung Ca  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb.   
Due to (or as a consequence of):c.   
Due to (or as a consequence of):d.   
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

1 year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accidental 3 ☐ Suicidal 4 ☐ Homicidal  
5 ☐ Pending Investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D33293

29d. Date signed (Month, Day, Year)

12-17-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FREDERICK P. SMITH, M.D., 5401 WESTERN AVENUE, N.W., WASHINGTON, D.C. 20015

31. Date filed (Month, Day, Year)

DEC 18 1997

32. Registrar's Signature



Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39630

|   |   |  |   |  |   |   |
|---|---|--|---|--|---|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>MARGARET ANN NULL</b>  |  | 2. Date of Death<br>Month Day Year<br><b>DECEMBER 11, 1997</b>  |  | 3. Time of Death<br><b>12:55 AM</b>   |   |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>Saint Joseph Medical Center</b>  |  | 4b. City, Town, or Location of Death<br><b>Towson</b>   |  | 4c. County of Death<br><b>Baltimore</b>   |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>236-58-7860</b>   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>59</b> Yrs.  | If Under 1 Year<br>Months Days                         | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>FEB 5, 1938</b> |
|   | 9. Birthplace (State or Foreign Country)<br><b>OHIO</b>   |  |   |  |   |   |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |  | 10e. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>BALTIMORE</b>   |   |
|   | 10c. City, Town or Location<br><b>UPPERCO</b>   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |   |
|   | 10e. Street and Number<br><b>17116 RIDGE ROAD</b>   |  | 10f. Zip Code<br><b>21155</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |   |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>3</b>  |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>INSURANCE BENEFITS COORDINATOR</b>   |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>ARTHUR SAMUEL FERGUSON, SR.</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>CATHERYNNNE ADAMS</b>   |  | 16b. Kind of Business/Industry<br><b>AT&amp;T</b>   |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>RUSSELL P. NULL, JR, HUSBAND</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>17116 RIDGE ROAD, UPPERCO, MD 21155</b>   |  |   |   |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                             |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MARBURG MEM GARDENS</b>  |  | 20c. Location - City or Town, State<br><b>12/13 HANOVER, PA</b>   |   |
|   | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>ELINE FUNERAL HOME 934 SOUTH MAIN ST, HAMPSTEAD, MD 21074</b>  |  |   |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>METASTATIC CANCER OF PANCREAS</b>                           |  |   |  |   |   |
| Physician<br>/Medical<br>Examiner   | Immediate Cause (Final disease or condition resulting in death)   |  | Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death  |   |
|   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  | Due to (or as a consequence of):  |  |   |   |
|   |   |  | Due to (or as a consequence of):  |  |   |   |
|   |   |  | Due to (or as a consequence of):  |  |   |   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |   |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |  |   |   |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |   |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |   |
|   | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 8 <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |   |
|   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |  |   |   |
| 29b. Signature and title of certifier<br>   |   | 29c. License number<br><b>D 37254</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>12-11-97</b> |   |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>BOON P. LIM, M.D., 7620 YORK ROAD TOWSON, MARYLAND 21204</b>   |   |  |   |  |   |   |
| State<br>Registrar  | 31. Date filed (Month, Day, Year)<br><b>DEC 16 1997</b>   |  | 32. Registrar's Signature<br>   |  |   |   |

Baltimore, Maryland 21215-0020

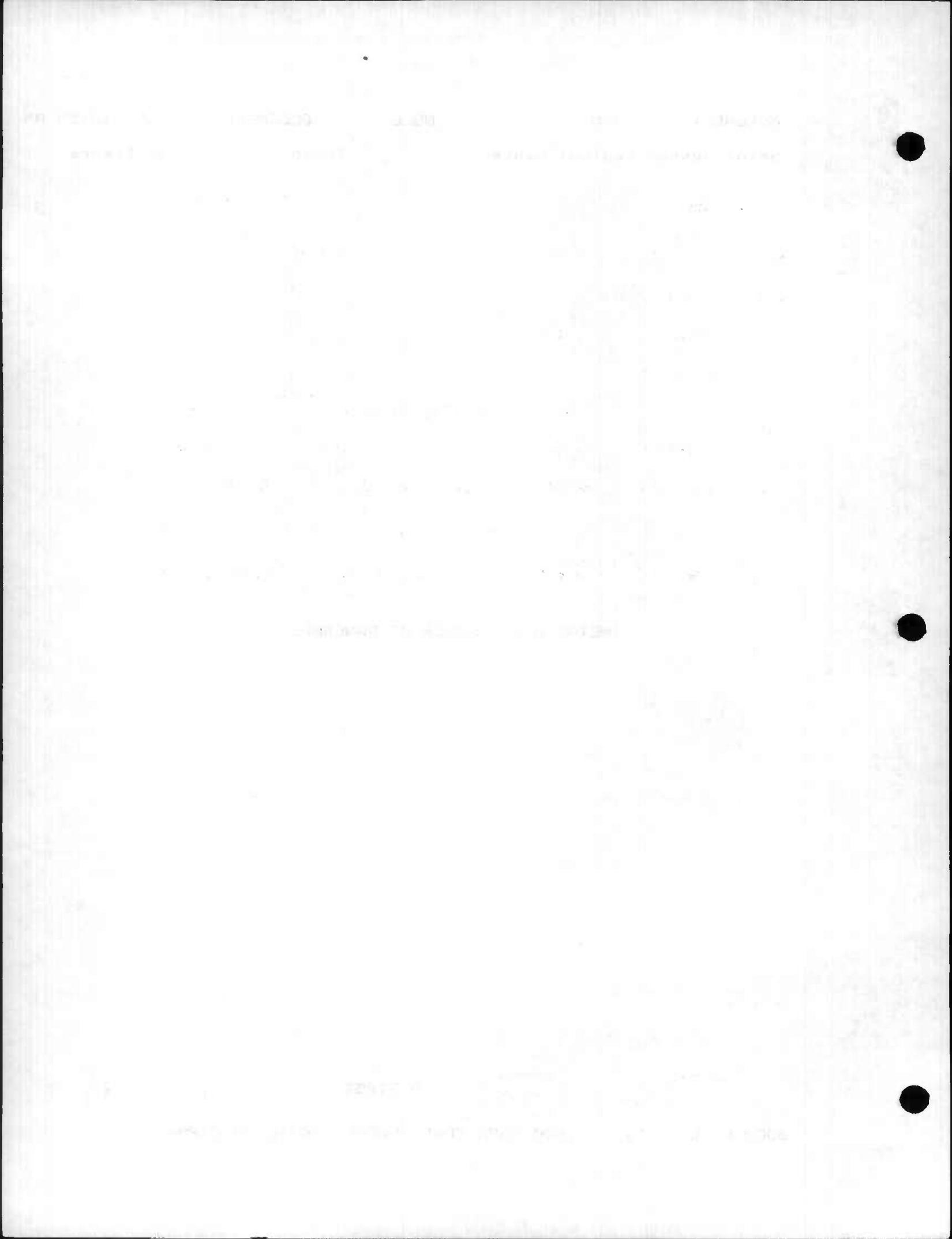
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39631

|   |   |   |  |                               |  |  |  |   |  |
|---|---|---|--|-------------------------------|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>W. Carl Naylor  |   |  |                               | 2. Date of Death<br>Month: December, Day: 12, Year: 1997   |  | 3. Time of Death<br>10:45 PM   |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Manor Care Health Services Bethesda   |   |  |                               | 4b. City, Town, or Location of Death<br>Bethesda   |  | 4c. County of Death<br>Montgomery  |   |  |
| Funeral<br>Director   | 5. Social Security Number<br>216-12-0528  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>80 Yrs.  | If Under 1 Year<br>Months     | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>March 4, 1917   |  | 9. Birthplace (State or Foreign Country)<br>West Virginia |  |
|   | Usual Residence of Decedent   |   |  |                               |  |  |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland  |   | 10b. County<br>Montgomery  |                               | 10c. City, Town or Location<br>Bethesda  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |  |
|   | 10e. Street and Number<br>9910 Holmhurst Road   |   |  |                               | 10f. Zip Code<br>20817   |  | 10g. Citizen of What Country?<br>United States   |   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WWII |                               | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4   |   | 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Sales Representative                          |                               | 16b. Kind of Business/Industry<br>Pharmaceutical Company   |  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br>Walter L. Naylor   |   |  |                               | 18. Mother's Name (First, Middle, Maiden Surname)<br>Elfa E. Sallaz  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>Rex V. Naylor (brother)   |   |  |                               | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>9910 Holmhurst Road, Bethesda, Maryland 20817   |  |  |   |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Chesapeake Crematory   |                               | Date<br>12-13-97   |  | 20c. Location - City or Town, State<br>Beltsville, Maryland  |   |  |
|   | 21. Signature of Funeral Service Licensee<br>Eileen H. Rapp   |   |  |                               | 22. Name and Address of Facility<br>Rapp Funeral Services, P.A.<br>933 Gist Avenue, Silver Spring, Maryland 20910  |  |  |   |  |
|   | 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |  |                               |  |  |  |   |  |
|   | <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. Cardiopulmonary Arrest</p> <p>Due to (or as a consequence of):</p> <p>b. Metastatic Carcinoma</p> <p>Due to (or as a consequence of):</p> <p>c.</p> <p>Due to (or as a consequence of):</p> <p>d.</p> <p>Sequently list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last</p> |   |  |                               |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |                               |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |   |  |
|   |   |   |  |                               |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |
|   |   |   |  |                               |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |                               |  |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M      |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how Injury occurred                         |  |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |                               |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |  |                               |  |  |  |   |  |
| 29b. Signature and title of certifier<br>Daniel J. Esposito   |   |   |  | 29c. License number<br>D23783 |  | 29d. Date signed (Month, Day, Year)<br>December 13, 1997   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Daniel J. Esposito, M.D., 5530 Wisconsin Avenue, #1400, Chevy Chase, MD 20815   |   |   |  |                               |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br>DEC 15 1997  |   | 32. Registrar's Signature<br>J. Davidson  |  |                               |  |  |  |   |  |

Baltimore, Maryland 21215-0020

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Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39632

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Gary Leigh Nordan

2. Date of Death

Month Day Year  
December 11, 1997

3. Time of Death

7:45 AM

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

243-72-2147

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

52

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 26, 1945

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10411 Farnham Drive

10f. Zip Code

20814

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1968-1972

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Attorney

16b. Kind of Business/Industry

Federal Energy Regulatory Commission

17. Father's Name (First, Middle, Last)

Henry Leigh Nordan

18. Mother's Name (First, Middle, Maiden Surname)

Mildred Carrick

19a. Informant's Name/Relationship (Type, Print)

Betty H. Nordan/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10411 Farnham Drive, Bethesda, Maryland 20814

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Montgomery Crematorium, Inc

Date

December 15, 1997

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home  
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue  
Bethesda, Maryland 20814-3501

23. Part II. Underlying cause of death, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Colon Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D 04766

29d. Date signed (Month, Day, Year)

December 11, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Daniel Rosenblum, M.D. 10400 Connecticut Avenue #606 Kensington, Maryland 20895

31. Date filed (Month, Day, Year)

DEC 17 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Nordan, Gary  
Division of Vital Records, P.O. Box 68760,  
Baltimore, Dec. 11, 1997 7:45 AM

30+1



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 39633

## Certificate of Death

Reg. No.

|  |  |   |  |  |   |  |  |  |  |  |
|--|--|---|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>ELLEN LOUISE NEWMAN                                  |   |  |  | 2. Date of Death<br>Month Day Year<br>DEC. 09TH, 1997 |  |  |  | 3. Time of Death<br>4:05AM                           |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>PRINCE GEORGES HOSPITAL CENTER |   |  |  | 4b. City, Town, or Location of Death<br>CHEVERLY      |  |  |  | 4c. County of Death<br>PRINCE GEORGES                |  |
| Funeral<br>Director  | 5. Social Security Number<br>578-28-3176   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>76 Yrs.             |  | 8. Date of Birth (Month, Day, Year)<br>July 7 1921 |  | 9. Birthplace (State or Foreign Country)<br>VIRGINIA |  |
|  | Usual Residence of Decedent  |   |  |  | 10a. State<br>MARYLAND                                |  | 10b. County<br>PRINCE GEORGES                      |  | 10c. City, Town or Location<br>BLADENSBURG           |  |
| 10e. Street and Number<br>4100 53RD AVE. #2  |  | 10f. Zip Code<br>20710  |  | 10g. Citizen of What Country?<br>UNITED STATES   |   |  |  |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: BLACK                     |  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12TH<br>College (1-4or 5+) Collage  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>MANAGER OF TIP TOP INN                   |  | 16b. Kind of Business/Industry<br>PRIVATE  |   |  |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>HARRISON CAMPBELL   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>CATHERINE LOGAN   |   |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>ELLWOOD NEWMAN, JR. / SON  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6645 GEORGIA AVE. N.W., WASH., D.C. 20012   |   |  |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>FT. LINCOLN CEMETERY  |  | Date<br>12-15-97   |   | 20c. Location - City or Town, State<br>BRENTWOOD, MARYLAND                           |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>Edward M. Dudley  |  | 22. Name and Address of Facility<br>DUDLEY FUNERAL HOME<br>3200 RHODE ISLAND AVE., MT. RAINIER, MD 20712  |  |  |   |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. END STAGE RENAL DISEASE<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>PNEUMONIA |  |   |  |  |   |  |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |   |  |  |   |  |  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |   |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |  |   |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |   |  |  |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)   |  |   |  |  |   |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred              |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br>R. L. H. M.D.   |  |   |  | 29c. License number<br>D48213  |   |  |  | 29d. Date signed (Month, Day, Year)<br>12-9-97 |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>N. ASHAI 4000 MITCHELLVILL ROAD #220, BOWIE, MARYLAND 20716  |  |   |  |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>DEC 17 1997   |  |   |  | 32. Registrar's Signature<br>John...   |   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State  
Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39634

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph J. Noll

2. Date of Death

Month Day Year  
Dec. 13, 1997

3. Time of Death

3:56 P.M.

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

578 03 4082

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

June 5, 1917

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Seabrook

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

6802 97th Place

10f. Zip Code

20706

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married

☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Owner

16b. Kind of Business/Industry

Retail Auto Parts

17. Father's Name (First, Middle, Last)

Stephan Noll

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Distl

19a. Informant's Name/Relationship (Type, Print)

Jo Ann M. Rich Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1407 Walden Court Crofton Maryland 21114

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State

☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

Dec. 17, 1997

20c. Location - City or Town, State

Suitland Maryland

21. Signature of Funeral Service Licensee

*Robert E. Evans*

22. Name and Address of Facility

Robert E. Evans Funeral Home, Inc.

16000 Annapolis Rd. Bowie Maryland 20715

23a. Part I. Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Cardiorespiratory Arrest

1 Hr

Due to (or as a consequence of):

b. Acute Myocardial Infarction

1 Hr

Due to (or as a consequence of):

c. Arteriosclerotic Cardiovascular Disease

20 Yrs

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus, Type 2

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient

☒ Outpatient

☐ DOA

Other:

☐ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural

☐ Accident

☐ Suicide

☐ Homicide

☐ Pending Investigation

☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Physician

☐ Medical Examiner

15. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Andres C. Lara, M.D.*

29c. License number

D16197

29d. Date signed (Month, Day, Year)

12-15-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Andres C. Lara, M.D.

9326 Lanham-Severn Road, Lanham, Maryland 20706

31. Date filed (Month, Day, Year)

DEC 17 1997

32. Registrar's Signature

*John Anderson*

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

THE UNIVERSITY OF CHICAGO

DEC 21 1930

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 39635

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CAROLINE

OSBORNE

2. Date of Death

Month Day Year  
December 9, 1997

3. Time of Death

6:45 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

214-34-9960

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

(Month, Day, Year)  
Sept. 3, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1634 Andover Lane

10f. Zip Code

21702

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

factory worker

16b. Kind of Business/Industry

rubber co.

17. Father's Name (First, Middle, Last)

Dewy Samson Kinna

18. Mother's Name (First, Middle, Maiden Surname)

Viola Jane Ramsburg

19a. Informant's Name/Relationship (Type, Print)

Kenneth E. Crum/ son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1634 Andover Lane Frederick, MD 21702

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chapel Cemetery

Date

12/12/97 nr. Libertytown, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licenses

*Catherine O. Vanter*

22. Name and Address of Facility

Hartzler Funeral Home  
11802 Liberty Rd. Libertytown, MD 21762

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 wks

b.

Left ventricular dysfunction / cardiomyopathy 5 yrs

Due to (or as a consequence of):

c.

Diabetes

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Acute cholecystitis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Gene F. Ash*

29c. License number

D3105P

29d. Date signed (Month, Day, Year)

12/9/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gene F. Ash, 10200 Coppermine Rd, Woodlawn, MD 21798

31. Date filed (Month, Day, Year)

DEC 11 1997

32. Registrar's Signature

*John A. Randall*State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39636

|  |   |   |  |  |  |   |   |  |  |   |  |
|--|---|---|--|--|--|---|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Thomas John Owen</b>                         |   |  |  | 2. Date of Death<br>Month <b>Dec.</b> Day <b>13</b> Year <b>1997</b> |   |   |  | 3. Time of Death<br><b>10:00 a.m.</b>    |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>6006 Onondaga Road</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Bethesda</b>              |   |   |  | 4c. County of Death<br><b>Montgomery</b> |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>579.46.4566</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>63</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                                       | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 27, 1934</b>                                 |   | 9. Birthplace (State or Foreign Country)<br><b>Washington, DC</b>  |  |   |  |
|  | Usual Residence of Decedent   |   |  |  |  |   |   |  |  |   |  |
| 10a. State<br><b>MD</b>  |   | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Bethesda</b>   |  |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |
| 10e. Street and Number<br><b>6006 Onondaga Road</b>  |   |   |  | 10f. Zip Code<br><b>20816</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |   |  |  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1957-1959</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b> |  |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>+4</b> College (1-4or 5+)  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Bank President</b>   |  |   | 16b. Kind of Business/Industry<br><b>Banking</b>                        |  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Thornton W. Owen</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Collette Radleveck</b>   |  |   |   |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Sally Owen Wife</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6006 Onondaga Road, Bethesda, MD 20816</b>   |  |   |   |  |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory, or other place)<br><b>Mount Comfort Crematory</b>   |  | Date<br><b>12/15/97</b>  |  | 20c. Location - City or Town, State<br><b>Alexandria, Virginia</b>                          |   |  |  |   |  |
| 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br><b>Joseph Gawler's Sons, Inc.<br/>5130 Wisconsin Avenue NW Washington DC 20016</b>   |  |   |   |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Non-Small Cell Cancer Of Lung</b><br>e. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>f. Due to (or as a consequence of):<br>g. Due to (or as a consequence of):<br>h. Due to (or as a consequence of): |   |   |  |  |  |   |   |  |  | Approximate Interval Between Onset and Death<br><b>1 year</b> |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |  |
|  |   |   |  |  |  |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |
|  |   |   |  |  |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |   |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how Injury occurred  |  |   |  |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |   |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   | 29b. Signature and title of certifier<br>  |  |  |  | 29c. License number<br><b>MD000025311</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>December 13, 1997</b>  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>W. Tabb Moore, M.D. 3301 New Mexico Avenue, N.W. 20016</b>  |   |   |  |  |  |   |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 16 1997</b>  |   | 32. Registrar's Signature<br>  |  |  |  |   |   |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 39637

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William Glenn Oliver

2. Date of Death

Month Day Year

December 10 1997

3. Time of Death

4:25am

4e. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

---

Funeral  
Director

5. Social Security Number

212-03-5570

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 7, 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

---

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

111 Hamlet Hill Road

10f. Zip Code

21210

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Insurance Agent

16b. Kind of Business/Industry

Insurance

17. Father's Name (First, Middle, Last)

Charles (NMN) Oliver

18. Mother's Name (First, Middle, Maiden Surname)

Caroline (NMN) Taylor

19a. Informant's Name/Relationship (Type, Print)

Iris S. Oliver/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

111 Hamlet Hill Road, Baltimore, MD 21210

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Spesutia Cemetery

Date

12-13-97 Perryman, Maryland

21. Signature of Funeral Service Licensee

Charles A. Emge Jr.

22. Name and Address of Facility

Howard K. McComas III Funeral Home, P.A.

1317 Cokesbury Road, Abingdon, Maryland 21009

Immediate Cause (Final  
disease or condition  
resulting in death)

a. Gastrointestinal bleed following 12 hour

Due to (or as a consequence of):

b. resuscitation following 12 hour

Due to (or as a consequence of):

c. respiratory and cardiovascular arrest following 12 hour

Due to (or as a consequence of):

d. airway obstruction from foreign body

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure, hypertension, anemia,

Hypercholesterolemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
Investigation  
2 ☒ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

December 9, 1997

28b. Time of  
Injury

4:30 PM

28c. Injury et  
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Choked on food

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

Restaurant - Cross Keys Inn

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

5100 Falls Rd 21210

29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David Blass MD

29c. License number

AS 2402321-DB-9854

29d. Date signed (Month, Day, Year)

December 11, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

David Blass MD Sinai Hospital of Baltimore

31. Date filed (Month, Day, Year)

DEC 16 1997

32. Registrar's Signature

John A. Randall

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 39638

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ALICE HOWETH PARKER

2. Date of Death

Month Day Year  
DEC. 18 1997

3. Time of Death

4:40AM

4a. Facility Name (If not Institution, give street and number)

5174 WESLEY ROAD

4b. City, Town, or Location of Death

HURLOCK

4c. County of Death

DORCHESTER

Funeral  
Director

5. Social Security Number

219-01-6559

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

March 11, 1911

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

DORCHESTER

10c. City, Town or Location

RHODESDALE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5112 RHODESDALE-VIENNA ROAD

10f. Zip Code

21659

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TEACHER

16b. Kind of Business/Industry

ELEMENTARY SCHOOL

17. Father's Name (First, Middle, Last)

SYLVESTER DAIL HOWETH

18. Mother's Name (First, Middle, Maiden Surname)

LINNIE ENGLISH

19a. Informant's Name/Relationship (Type, Print)

ELLEN P. ROTHFELDER/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

36923 PINWOOD STREET, WAYNE, MICHIGAN 48184

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

EAST NEW MARKET CEMETERY 12/21

Date

20c. Location - City or Town, State

EAST NEW MARKET, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ZELLER FUNERAL HOME, P. O. BOX 207,  
106 MAIN STREET, EAST NEW MARKET, MD 21631

23a. Part I. Enter the disease, or multiple conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

2 wks

Due to (or as a consequence of):

b. Generalized Atherosclerotic Disease

1 yr

Due to (or as a consequence of):

c. CVA with 2 Hemipareses

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

H/O Breast Cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Fadden MD 302 Collins Hurlock MD 21643

31. Date filed (Month, Day, Year)

DEC 22 1997

32. Registrar's Signature

John Davidson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39639

|   |   |  |   |  |  |  |   |  |
|---|---|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>MARION POWELL, SR</b>  |  |   |  | 2. Date of Death<br>Month <b>DEC.</b> Day <b>14,</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>4:40 AM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>9815 Whiskey Run</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Laurel</b>  |  | 4c. County of Death<br><b>PRINCE GEORGES</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>218-24-0151</b>   |  | 6. Sex<br><b>1</b> Male <b>2</b> Female |  | 7. Age (In yrs. last birthday)<br><b>68</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 24, 1929</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10a. State<br><b>MD</b>                 |  | 10b. County<br><b>PRINCE GEORGES</b>   |  | 10c. City, Town or Location<br><b>Washington, DC</b>  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No   |  |   |  | 10e. Street and Number<br><b>601 L Street, SE</b>  |  | 10f. Zip Code<br><b>20003</b>   |  |
|   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |   |  | 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates:  |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify:   |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11th</b> College (1-4 or 5+) <b>College</b> |  |
|   | 16. Kind of Business/Industry<br><b>Auto Service</b>  |  |   |  | 17. Father's Name (First, Middle, Last)<br><b>William Powell, Sr.</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elizabeth Williams</b>  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Vivian Mason (Daughter)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9815 Whiskey Run, Laurel, MD 20723</b>                                       |  |   |  |
|   | 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Zion Church Cem</b>   |  | 20c. Location - City or Town, State<br><b>Laurel, MD</b>  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><i>George R. Brandon</i>   |  |   |  | 22. Name and Address of Facility<br><b>SNOWDEN FUNERAL HOME, P.A.<br/>ROCKVILLE, MD 20850</b>  |  |   |  |
|   | 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Larynx Cancer</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |  | Approximate Interval Between Onset and Death<br><b>2 years</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown  |  |   |  |
|   | 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |  |   |  |
|   | 27. Manner of Death<br><b>1</b> Natural <b>2</b> Accident <b>3</b> Suicide <b>4</b> Homicide<br><b>5</b> Pending Investigation <b>6</b> Could not be determined   |  |   |  | 28a. Date of Injury (Month, Day, Year)<br><b>12/20/97</b>  |  | 28b. Time of Injury<br><b>M</b>   |  |
| To Be Completed by Physician/Medical Examiner | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No  |  |   |  | 28d. Describe how injury occurred  |  |   |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  | 29b. Signature and title of certifier<br><i>David J. Perry MD</i>  |  |   |  |
|   | 29c. License number<br><b>DC-18561</b>  |  |   |  | 29d. Date signed (Month, Day, Year)<br><b>12/16/97</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>David J. Perry, M.D. 110 Irving St., NW, Washington, DC 20010</b>  |  |   |  | 31. Date filed (Month, Day, Year)<br><b>DEC 17 1997</b>  |  |   |  |
|   | 32. Registrar's Signature<br><i>J. Davidson-Randall</i>   |  |   |  |  |  |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39640

|   |   |  |   |  |  |  |   |  |
|---|---|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Hyo Soon Park   |  |   |  | 2. Date of Death<br>Month Day Year<br>December 15, 1997  |  | 3. Time of Death<br>3:40 P.M.                                     |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>SHADY GROVE ADVENTIST HOSPITAL  |  |   |  | 4b. City, Town, or Location of Death<br>ROCKVILLE  |  | 4c. County of Death<br>MONTGOMERY                                 |  |
| Funeral<br>Director   | 5. Social Security Number<br>578-04-0118  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>78 Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>Sept. 15, 1919             |  |
|   | 9. Birthplace (State or Foreign Country)<br>Korea   |  |   |  |  |  |   |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |  |   |  |  |  |   |  |
|   | 10a. State<br>Maryland  |  | 10b. County<br>Montgomery   |  | 10c. City, Town or Location<br>Gaithersburg  |  |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
|   | 10e. Street and Number<br>101 Odendhall Avenue, # 407   |  |   |  | 10f. Zip Code<br>20877   |  | 10g. Citizen of What Country?<br>United States                    |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Korean |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10 College (1-4or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Diplomat  |  | 16b. Kind of Business/Industry<br>U.S. Embassy                    |  |
|   | 17. Father's Name (First, Middle, Last)<br>Un Kyung Park  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Unknown Jun   |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Choon Ja Park/ Wife   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>101 Odendhall Ave., # 407, Gaithersburg, MD. 20877  |  |   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Gate of Heaven Cemetery   |  | Date<br>12/19/97   |  | 20c. Location - City or Town, State<br>Silver Spring, MD.         |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Michael D. Carlbay</i>  |  |   |  | 22. Name and Address of Facility<br>DeVol Funeral Home<br>10 East Deer Park Dr., Gaithersburg, MD. 20877   |  |   |  |
|   | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                       |  |   |  |  |  |   |  |
| Immediate Cause (Final disease or condition resulting in death)<br>a. ACUTE MYOCARDIAL INFARCTION<br>Due to (or as a consequence of):<br>b. CORONARY ARTERY DISEASE<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.   |   |  |   |  |  |  |   | 2 hours<br>years   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |   |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
|   |   |  |   |  |  |  |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |
|   |   |  |   |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |
|   |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |   | 28d. Describe how injury occurred  |  |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><i>[Signature]</i> M.D.                       |   | 29c. License number<br>D37024  |  | 29d. Date signed (Month, Day, Year)<br>December 15, 1997                             |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>DAVID SNAR 9901 Medical Center Dr. Rockville Md. 20850  |   |  |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br>DEC 18 1997  |   |  |   | 32. Registrar's Signature<br><i>[Signature]</i>  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39641

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ANGEL STAR PINCKNEY

2. Date of Death

Month Day Year  
DECEMBER 10, 1997

3. Time of Death

06:51 AM

4a. Facility Name (If not institution, give street and number)

PRINCE GEORGES HOSPITAL CENTER

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

PRINCE GEORGES

Funeral  
Director

5. Social Security Number

219-15-6296

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

17 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

April 4, 1980

9. Birthplace (State or Foreign Country)

Wash., D.C.

Usual Residence of Decedent

10a. State

Maryland Prince George's

10b. County

10c. City, Town or Location

Capitol Heights

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

419 Larchmont Ave.

10f. Zip Code

20743

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Student

16b. Kind of Business/Industry

NA

17. Father's Name (First, Middle, Last)

John Pinckney, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Sylvia Slater

19a. Informant's Name/Relationship (Type, Print)

John Pinckney, Jr. / Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

419 Larchmont Ave., Capitol Heights, MD 20743

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Lincoln Memorial Cem.

Date

12/15/97

20c. Location - City or Town, State

Suitland, MD

21. Signature of Funeral Service Licensee

John T. Stewart, III

22. Name and Address of Facility

Stewart Funeral Home

4001 Benning Rd., N.E. Washington, D.C. 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. LUNG CANCER

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient3 ☒ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated

29b. Signature and title of certifier

[Signature]

29c. License number

D33954

29d. Date signed (Month, Day, Year)

DECEMBER 10, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARIO F. GOLUB JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

31. Date filed (Month, Day, Year)

DEC 15 1997

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 39642

## Certificate of Death

Reg. No.

|  |   |   |   |   |  |
|--|---|---|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><i>MARY POSEY</i>   |   | 2. Date of Death<br>Month <i>December</i> Day <i>13</i> Year <i>1997</i>  |   | 3. Time of Death<br><i>4:20pm</i>  |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>Washington Adventist Hospital</i>  |   | 4b. City, Town, or Location of Death<br><i>Takoma Park</i>  |   | 4c. County of Death<br><i>Montgomery</i>   |
| Funeral<br>Director  | 5. Social Security Number<br><i>579-26-5709</i>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><i>71</i> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   |
|  | 8. Date of Birth (Month, Day, Year)<br><i>Mar. 14, 1926</i>   |   | 9. Birthplace (State or Foreign Country)<br><i>Washington, DC</i>   |   |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent   |   | 10c. City, Town or Location<br><i>Riverdale</i>   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|  | 10a. State<br><i>Maryland</i>   | 10b. County<br><i>Prince George's</i>   |   |   |  |
|  | 10e. Street and Number<br><i>5900 62nd Avenue</i>   |   | 10f. Zip Code<br><i>20737</i>   |   | 10g. Citizen of What Country?<br><i>U.S.A.</i>   |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i>   |   | 15. Decedent's Education (Specify only highest grade completed)<br><i>Elementary/Secondary (0-12)</i><br><i>12</i>                                  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Homemaker</i>  |
|  | 16b. Kind of Business/Industry<br><i>Own Home</i>   |   | 17. Father's Name (First, Middle, Last)<br><i>Perry Thompson</i>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Florence Barrett</i>   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><i>Vernon R. Posey - Husband</i>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>5900 62nd Avenue, Riverdale, Maryland 20737</i> |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Maryland Veterans Cemetery</i>   |   | 20c. Location - City or Town, State<br><i>Cheltenham, Maryland</i>   |
|  | 21. Signatura of Funeral Service Licensee<br><i>Claudette S. Dooch</i>  |   | 22. Name and Address of Facility<br><i>Francis Gasch's Funeral Home, P.A.<br/>4739 Baltimore Avenue, Hyattsville, MD 20781</i>                      |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <i>Sepsis</i><br>Due to (or as a consequence of):<br>b. <i>End stage renal disease</i><br>Due to (or as a consequence of):<br>c. <i>Severe coronary artery disease</i><br>Due to (or as a consequence of):<br>d. <i>Recent myocardial infarction</i> |   |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>congestive heart failure</i><br><i>Anemia</i><br><i>Paroxysmal Atrial fibrillation</i>  |   |   |   |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)<br><i>M</i>  |   | 28b. Time of Injury<br><i>1</i> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                        |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |   |  |
| 29b. Signature and title of certifier<br><i>Thompson</i>   |   | 29c. License number<br><i>D 22111</i>   |   | 29d. Date signed (Month, Day, Year)<br><i>12/15/97</i>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>THOMPSON KO 8100 Good Luck Rd #302 Lanham MD 20706</i>  |   |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><i>DEC 18 1997</i>  |   | 32. Registrar's Signature<br><i>[Signature]</i>   |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 39643

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Frieda Marie Parker

2. Date of Death

December 11, 1997

3. Time of Death

10:45 pm

4a. Facility Name (If not institution, give street and number)

Manor Care Largo

4b. City, Town, or Location of Death

Largo

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

579-10-5108

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 25, 1907

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Capital Heights

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1408 Pine Grove Road

10f. Zip Code

20743

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Sales Person

16b. Kind of Business/Industry

Retail Sales

17. Father's Name (First, Middle, Last)

Traugott Lebrick Schmidt

18. Mother's Name (First, Middle, Maiden Surname)

Theresia Johanne von Fogel

19a. Informant's Name/Relationship (Type, Print)

Jack Parker - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9213 Briarship Street, Laurel, Maryland 20708

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Washington National Cemetery 12/16/97 Suitland, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Nancy J. Thompson

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.  
4739 Baltimore Avenue, Hyattsville, MD 2078123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

Atrial Fibrillation

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

3 years

b.

Coronary Artery Disease

Due to (or as a consequence of):

3 years

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

- Dementia (2 years)

- Atherosclerotic Cardiovascular

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Sam Tellawi

29c. License number

D34 274

29d. Date signed (Month, Day, Year)

12-15-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Sam Tellawi, M.D. 7700 Old Branch Avenue, Clinton, Maryland

31. Date filed (Month, Day, Year)

DEC 16 1997

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

87 39644

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Oliver Pratt

2. Date of Death

Month Day Year  
DECEMBER 11, 1997

3. Time of Death

20:38 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

ALCONA DRIVE AND ELLERBIE

4b. City, Town, or Location of Death

Lanham

4c. County of Death

PRINCE GEORGES

5. Social Security Number

578-98-3367

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

19 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
12-11-78

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Lanham

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

9304 Wyatt Drive

10f. Zip Code

20706

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married ☐ Married3 ☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Student

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Carolyn Pratt

19a. Informant's Name/Relationship (Type, Print)

Pauline Pratt/Grandmother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9304 Wyatt Drive, Lanham, Maryland 20706

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State4 ☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial park

Date

12/19/97

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

Charles J. Brown

22. Name and Address of Facility

J. B. Jenkins Funeral Home

7474 Landover Road, Landover, Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple gunshot wounds and

Due to (or as a consequence of):

Shotgun wound

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☒ Other (Specify) SCENE

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☒ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)  
12/11/97

28b. Time of Injury

UNK M

28c. Injury at Work?

1 ☐ Yes ☒ No

28d. Describe how injury occurred

Subject shot

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

STREET

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Ellerbie and Alconia St. 20706

29a. Certifier  
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. LARON LOCKE, MD

29c. License number

OCME

29d. Date signed (Month, Day, Year)

DECEMBER 12, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. LARON LOCKE, MD

111 Penn Street, Baltimore, Maryland 21201

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 17 1997

32. Registrar's Signature

John A. Marshall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

These are not the same as the  
I have seen before

X

X

X

These are not the same as the  
I have seen before

These are not the same as the  
I have seen before

X

(These are not the same as the  
I have seen before)  
The same as the one I  
have seen before

1847 1030

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39645

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Howard Eugene Penn

2. Date of Death

Month Day Year  
Dec. 12, 1997

3. Time of Death

19:25 PM

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

577-62-4411

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

50

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 2, 1947

9. Birthplace (State or Foreign Country)

South Boston, VA

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

615 Edmonston Drive

10f. Zip Code

20851

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:  
Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3 years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Unavailable

16b. Kind of Business/Industry

DC Housing Authority

17. Father's Name (First, Middle, Last)

Unavailable

18. Mother's Name (First, Middle, Maiden Surname)

Eva Mae

19a. Informant's Name/Relationship (Type, Print)

Evernezer P. Penn Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

615 Edmonston Drive, Rockville, MD 20851

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Washington National Cemetery

Date

12/17/97

20c. Location - City or Town, State

Suitland, MD

21. Signature of Funeral Service Licensee

David Rathay - Solomon

22. Name and Address of Facility

Latney's Funeral Home, Inc.  
3831 Georgia Ave, NW Wash, DC 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Intracerebral Hemorrhage

Due to (or as a consequence of):

50 hr.

b. Hypertension

Due to (or as a consequence of):

5 years

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Diabetes Melitus

Due to (or as a consequence of):

5 years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☒ Inpatient☐ ER/Outpatient☐ DOAOther: ☐ Nursing Home☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. Marmus

29c. License number

D 40353

29d. Date signed (Month, Day, Year)

12/13/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Marmus 11119 Rockville Pike #320 Rockville MD 20852

31. Date filed (Month, Day, Year)

DEC 17 1997

32. Registrar's Signature

John Marmus

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

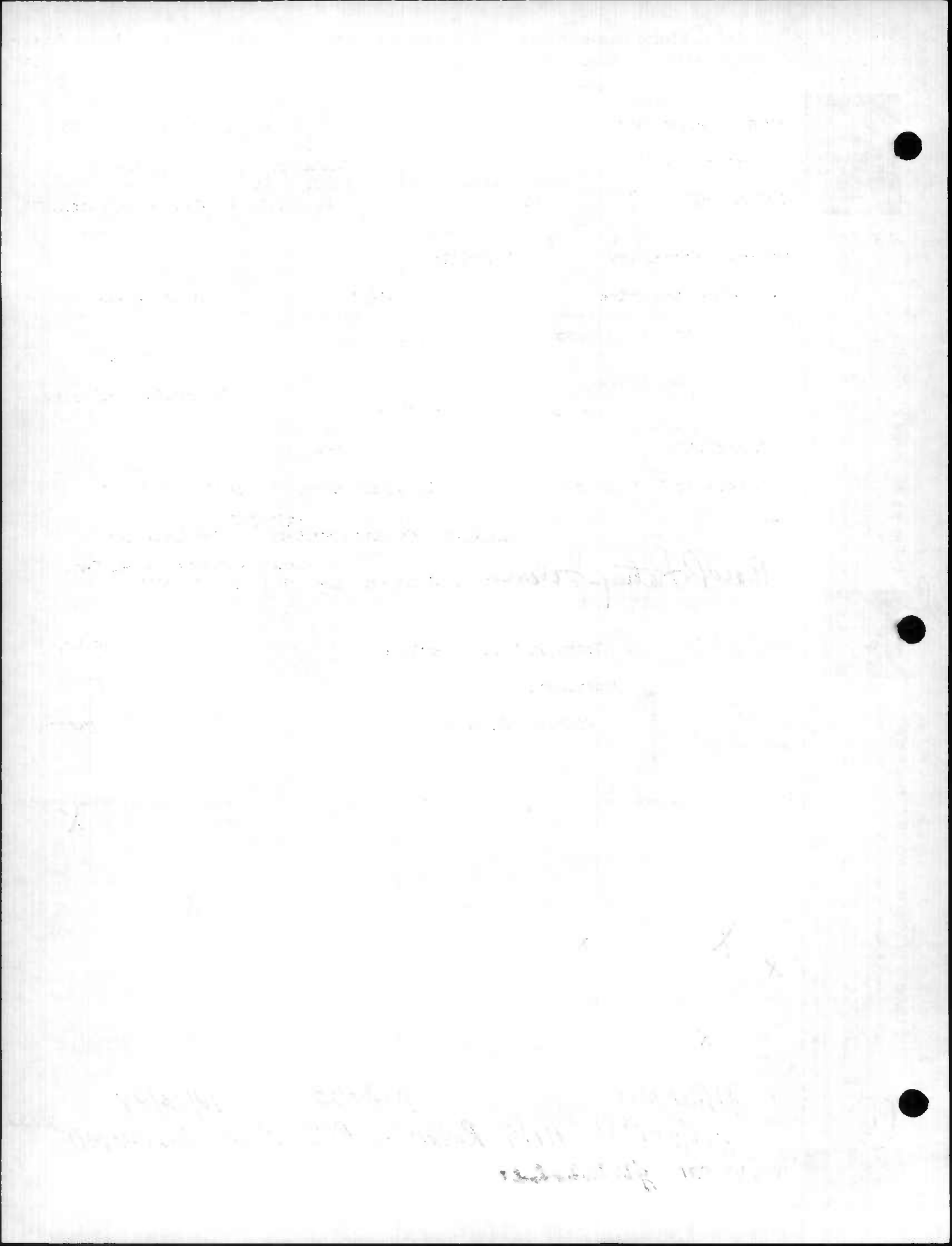
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND# 22 12-11-97 cms AACO HEALTH

Certificate of Death

Reg. No.

97 39646

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Minnie Alice Petty

2. Date of Death

Month Day Year  
December 9, 1997

3. Time of Death

8:15 am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

214-05-1091

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

May 22, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Severna Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

501 Pinetree Drive

10f. Zip Code

21146

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Assistant Manager

16b. Kind of Business/Industry

Banking

17. Father's Name (First, Middle, Last)

William Owings

18. Mother's Name (First, Middle, Maiden Surname)

Leicy J. Simmons

19a. Informant's Name/Relationship (Type, Print)

Marilyn Dytche Amoss/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2535 Baldwin Mill Road, Baldwin, MD 21013-9114

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

Dec 12 1997

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Barranco & Sons, P.S. Severna Park Funeral Home  
495 Gov. Ritchie Hwy., Severna Park, MD 21146

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Cerebrovascular accident

Approximate Interval Between Onset and Death

1 week

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

{

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Small cell lung cancer

Hypertension

Chronic obstructive lung disease

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]* Peter A. Gray MD

29c. License number

D16364

29d. Date signed (Month, Day, Year)

12/9/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Peter Gray 900 Beotgate Road Annapolis, MD 21401

31. Date filed (Month, Day, Year)

DEC 11 1997

32. Registrar's Signature

*[Signature]* John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39647

|   |   |  |   |                                |  |  |  |
|---|---|--|---|--------------------------------|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>ELIZABETH CATHERINE HARTENSTEIN PAWL</b>   |  |   |                                | 2. Date of Death<br>Month <b>DECEMBER</b> Day <b>8</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>9:30 AM</b>   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>1313 WILLIAMS STREET</b>   |  |   |                                | 4b. City, Town, or Location of Death<br><b>GLEN BURNIE</b>   |  | 4c. County of Death<br><b>ANNE ARUNDEL</b>   |
| Funeral<br>Director                           | 5. Social Security Number<br><b>219-32-1911</b>   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>MARCH 2, 1918</b>  | 9. Birthplace (State or Foreign Country)<br><b>VIRGINIA</b>  |
|   | Usual Residence of Decedent   |  |   |                                |  |  |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>MARYLAND</b>   | 10b. County<br><b>ANNE ARUNDEL</b>   | 10c. City, Town or Location<br><b>GLEN BURNIE</b>   |                                |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|   | 10e. Street and Number<br><b>1313 WILLIAMS STREET</b>   |  |   | 10f. Zip Code<br><b>21061</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>N/A</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SELF EMPLOYED</b>   |                                | 16b. Kind of Business/Industry<br><b>RESTAURANT &amp; TAVERN</b>   |  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>MINOR D. RODEFFER</b>   |  |   |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>GRACE D. EVANS</b>   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>BETTY G. JOHNS</b>   |  |   |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1313 WILLIAMS STREET, GLEN BURNIE, MARYLAND 21061</b>  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GLEN HAVEN MEMORIAL PARK</b>   |                                | Date<br><b>12/11/97</b>  | 20c. Location - City or Town, State<br><b>GLEN BURNIE, MD.</b>                                     |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>SINGLETON FUNERAL HOME,<br/>1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</b>  |                                |  |  |  |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>CORONARY ARTERY DISEASE</b><br>Due to (or as a consequence of):<br><b>Diabetes mellitus</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Stroke</b><br>Due to (or as a consequence of):<br><b>Alzheimer's Disease</b> |  |   |                                |  |  | Approximate Interval Between Onset and Death<br><b>5 years</b><br><b>20 years</b><br><b>5 years</b><br><b>10 years</b>   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |                                |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |                                |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 28. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |                                |  |  |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |                                | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
|   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred   |                                |  |  |  |
|   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |                                |  |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |                                |  |  |  |
| State Registrar                               | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>020094</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>12/09/97</b>   |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>7845 Oakwood Rd., Glen Burnie, Md., 21061</b>  |  |   |                                |  |  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>DEC 11 1997</b>   |  | 32. Registrar's Signature<br>   |                                |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 39648

DANIELLE PIERRE LOUIS

Items: 23a part 1, 27, 28a-f per MEO G-755 1/7/98 dh

## Certificate of Death

Reg. No.

|                                     |  |  |  |   |  |   |  |  |
|-------------------------------------|--|--|--|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>DANIELLE PIERRE-LOUIS</b>   |  |  |   | 2. Date of Death<br>Month Day Year<br><b>DEC. 3, 1997</b>  |   | 3. Time of Death<br><b>1417 PM</b>   |  |
|                                     | 4e. Facility Name (If not institution, give street and number)<br><b>SHADY GROVE HOSPITAL</b>  |  |  |   | 4b. City, Town, or Location of Death<br><b>GAITHERSBURG</b>  |   | 4c. County of Death<br><b>MONTGOMERY</b>   |  |
| Funeral<br>Director                 | 5. Social Security Number<br>(Unavailable)   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br>Yrs. <b>4</b> | If Under 1 Year<br>Months <b>4</b>   | If Under 24 Hrs.<br>Hours <b>4</b> Min. | 8. Date of Birth (Month, Day, Year)<br><b>JULY 25, 1997</b>  |  |
|                                     | Usual Residence of Decedent  |  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |   |  |   |  |  |
| To Be Completed by Funeral Director | 10a. State<br><b>MARYLAND</b>  |  | 10b. County<br><b>MONTGOMERY</b>   |   | 10c. City, Town or Location<br><b>GERMANTOWN</b>   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|                                     | 10e. Street and Number<br><b>19361 HOTTINGER CIRCLE</b>  |  |  |   | 10f. Zip Code<br><b>20874</b>  |   | 10g. Citizen of What Country?<br><b>UNITED STATES</b>  |  |
|                                     | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                            |  |
|                                     | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>None</b><br>College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>None</b>   |   | 16b. Kind of Business/Industry<br><b>None</b>  |   |  |  |
|                                     | 17. Father's Name (First, Middle, Last)<br><b>REYNOLD PIERRE-LOUIS</b>   |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marylin Pierre</b>   |   |  |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br><b>REYNOLD PIERRE-LOUIS FATHER</b>   |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>19361 HOTTINGER CIRCLE, GERMANTOWN, MD 20874</b>   |   |  |  |
|                                     | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ST. CHARLES CEMETERY</b>  |   | Date<br><b>12/13/97</b>  |   | 20c. Location - City or Town, State<br><b>FARMINGDALE, NY</b>                                      |  |
|                                     | 21. Signature of Funeral Service Licensee<br>  |  |  |   | 22. Name and Address of Facility<br><b>FULLERTON FUNERAL HOME, INC.<br/>769 MERRICK RD., BALDWIN, NY 11510</b>   |   |  |  |
|                                     | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>SUFFOCATION</b><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |   |  |   |  |  |
|                                     | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |  |   |  |  |
| Physician<br>/Medical<br>Examiner   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |  |
|                                     |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |  |
|                                     | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |   |  |  |
|                                     | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)<br><b>12/3/97</b>   |   | 28b. Time of Injury<br>P <b>M</b>  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No    |  |
|                                     | 28d. Describe how injury occurred<br><b>re-breathing air from coat hood</b>  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>13716 Wangarden Drive, Germantown, Md.</b>  |   |  |   |  |  |
|                                     | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |   |  |   |  |  |
|                                     | 29b. Signature and title of certifier<br>  |  |  |   | 29c. License number<br><b>O.C.M.E</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>DEC. 4, 1997</b>   |  |
|                                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201</b>  |  |  |   |  |   |  |  |
|                                     | 31. Date filed (Month, Day, Year)<br><b>DEC 12 1997</b>  |  | 32. Registrar's Signature<br>  |   |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39649

|   |  |                               |   |  |  |  |   |  |
|---|--|-------------------------------|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner                       | 1. Decedent's Name (First, Middle, Last)<br><b>Patricia Ann Powell</b>   |                               |   |  | 2. Date of Death<br>Month <b>Dec.</b> Day <b>16,</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>7:59 P.M.</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>2418 Greenheart Lane</b>  |                               |   |  | 4b. City, Town, or Location of Death<br><b>Edgewood</b>  |  | 4c. County of Death<br><b>Harford</b>   |  |
| Funeral<br>Director                                     | 5. Social Security Number<br><b>232-60-2868</b>  |                               | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>57</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 8, 1940</b>                                  | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b>   |
|   | Usual Residence of Decedent  |                               |   |  |  |  |   |  |
| To Be Completed by Funeral Director                     | 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Harford</b> | 10c. City, Town or Location<br><b>Edgewood</b>  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
|   | 10e. Street and Number<br><b>2418 Greenheart Lane</b>  |                               |   |  | 10f. Zip Code<br><b>21040</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |                               | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |                               | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Chief Administrative Officer</b>  |  | 16b. Kind of Business/Industry<br><b>County Government</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner           | 17. Father's Name (First, Middle, Last)<br><b>Leroy Elwood Simmons</b>   |                               |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Betty Louise Parker</b>  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ronald L. Powell - Husband</b>  |                               |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2418 Greenheart Lane, Edgewood, Maryland 21040</b>                                       |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |                               | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Bel Air Memorial Gardens</b>   |  | 20c. Location - City or Town, State<br><b>12-20-97 Bel Air, Maryland</b>   |  |   |  |
|   | 21. Signature of Funeral Service Licensee<br>  |                               | 22. Name and Address of Facility<br><b>Howard K. McComas III Funeral Home, P.A.<br/>1317 Cokesbury Road, Abingdon, MD 21009</b>   |  |  |  |   |  |
| Physician<br>/Medical<br>Examiner                       | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death)</b><br>a. <b>METASTATIC COLON CANCER</b><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                               |   |  |  |  |   | Approximate Interval Between Onset and Death<br><b>8 MONTHS</b>  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HEPATIC FAILURE</b>   |                               |   |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|   |  |                               |   |  |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|   |  |                               |   |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| State<br>Registrar                                      | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                               | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |                               | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|   |  |                               | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28d. Describe how injury occurred   |  |
|   |  |                               | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |
| State<br>Registrar                                      | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |                               |   |  |  |  |   |  |
|   | 29b. Signature and title of certifier<br>  |                               |   |  | 29c. License number<br><b>231775</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>DECEMBER 17, 1997</b>                             |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Joan P. Edwards, M.D., 2112 Belair Road, Fallston, Maryland 21047</b>   |                               |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 17 1997</b> |  | 32. Registrar's Signature<br> |   |  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item #26, per Phy.  
12/16/97, Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No. 97 39650

|   |   |  |  |                                      |  |   |  |  |
|---|---|--|--|--------------------------------------|--|---|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Raymond William Richard, Sr.  |  |  |                                      | 2. Date of Death<br>Month Day Year<br>Dec. 11, 1997  |   | 3. Time of Death<br>1:36 PM  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Carroll County General Hospital   |  |  |                                      | 4b. City, Town, or Location of Death<br>Westminster  |   | 4c. County of Death<br>Carroll   |  |
| Funeral<br>Director                           | 5. Social Security Number<br>233-52-8271  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>63 | 8. Date of Birth (Month, Day, Year)<br>Oct. 29, 1934   | 9. Birthplace (State or Foreign Country)<br>West Virginia |  |  |
|   | Usual Residence of Decedent   |  |  |                                      | 10a. State<br>Maryland   |   | 10b. County<br>Carroll   |  |
| To Be Completed by Funeral Director           | 10c. City, Town or Location<br>Woodbine   |  |  |                                      | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br>7429 John Pickett Rd.  |  |
|   | 10f. Zip Code<br>21797  |  |  |                                      | 10g. Citizen of What Country?<br>United States   |   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| To Be Completed by Physician/Medical Examiner | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1954-1956   |  |  |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10th College (1-4 or 5+) Self Employed   |  |  |                                      | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Self Employed  |   | 16b. Kind of Business/Industry<br>Home Improvement   |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br>Charles Richard  |  |  |                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br>Sylvia Smith  |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Barbara Richard (Wife)  |  |  |                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7429 John Pickett Rd. Woodbine, MD 21797  |   |  |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |                                      | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Crest Lawn Memorial Gar.   |   | 20c. Location - City or Town, State<br>12/15/97 Marriottsville, MD   |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  |  |                                      | 22. Name and Address of Facility<br>Burrier-Queen Funeral Home<br>1212 W. Old Liberty Rd.<br>Winfield, MD 21784  |   |  |  |
| To Be Completed by Physician/Medical Examiner | 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. ACUTE MYOCARDIAL INFARCTION<br>Due to (or as a consequence of):<br>b. SEPTICEMIA<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d. |  |  |                                      | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |   |  |  |
|   | 23c. Pert. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>END STAGE RENAL DISEASE<br>DIABETES MELITUS.  |  |  |                                      | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |                                      | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Hospice |   |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |  |                                      | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br>M   |  |
| To Be Completed by Physician/Medical Examiner | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |                                      | 28d. Describe how injury occurred  |   |  |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |                                      | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                         |  |  |                                      | 29b. Signature and title of certifier<br>Nammam Halabi, MD   |   |  |  |
|   | 29c. License number<br>D44206   |  |  |                                      | 29d. Date signed (Month, Day, Year)<br>12/11/97  |   |  |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>NAMMAN HALABI MD (ON BEHALF OF PMD DR ASSAR)  |  |  |                                      | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>CCGH, 200 Memorial Ave., Westminster, MD 21157   |   |  |  |
|   | 31. Date filed (Month, Day, Year)<br>DEC 16 1997  |  |  |                                      | 32. Registrar's Signature<br>John Andrew Randall   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39651

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edith K. Reilly

2. Date of Death  
Month Day Year

12/8/1997

3. Time of Death

1050 Am

4a. Facility Name (If not institution, give street and number)

1825 Vincenza Court

4b. City, Town, or Location of Death

Eldersburg

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

043-16-7545

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 23 1919

9. Birthplace (State or Foreign Country)

Connecticut

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Eldersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1825 Vincenza Court

10f. Zip Code

21784

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Assistant Manager

16b. Kind of Business/Industry

State Motor Vehicle Administration

17. Father's Name (First, Middle, Last)

Adolph Kremmell

18. Mother's Name (First, Middle, Maiden Surname)

Edith (unknown)

19a. Informant's Name/Relationship (Type, Print)

Betty A. Wallace (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6115 Rolling View Dr. Eldersburg MD 21784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lake View Cemetery

Date

12/12/97

20c. Location - City or Town, State

Bridgeport CT

21. Signature of Funeral Service Licensee

Harry W. Haight

22. Name and Address of Facility

Haight Funeral Home

P.O. Box 195 Sykesville MD 21784

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Squamous Cell Cancer of head &amp; neck

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sgt. Smith MD

29c. License number

028304

29d. Date signed (Month, Day, Year)

12/9/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

750 Main St.

Reisterstown MD

21134

31. Date filed (Month, Day, Year)

DEC 16 1997

32. Registrar's Signature

John Andrew Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

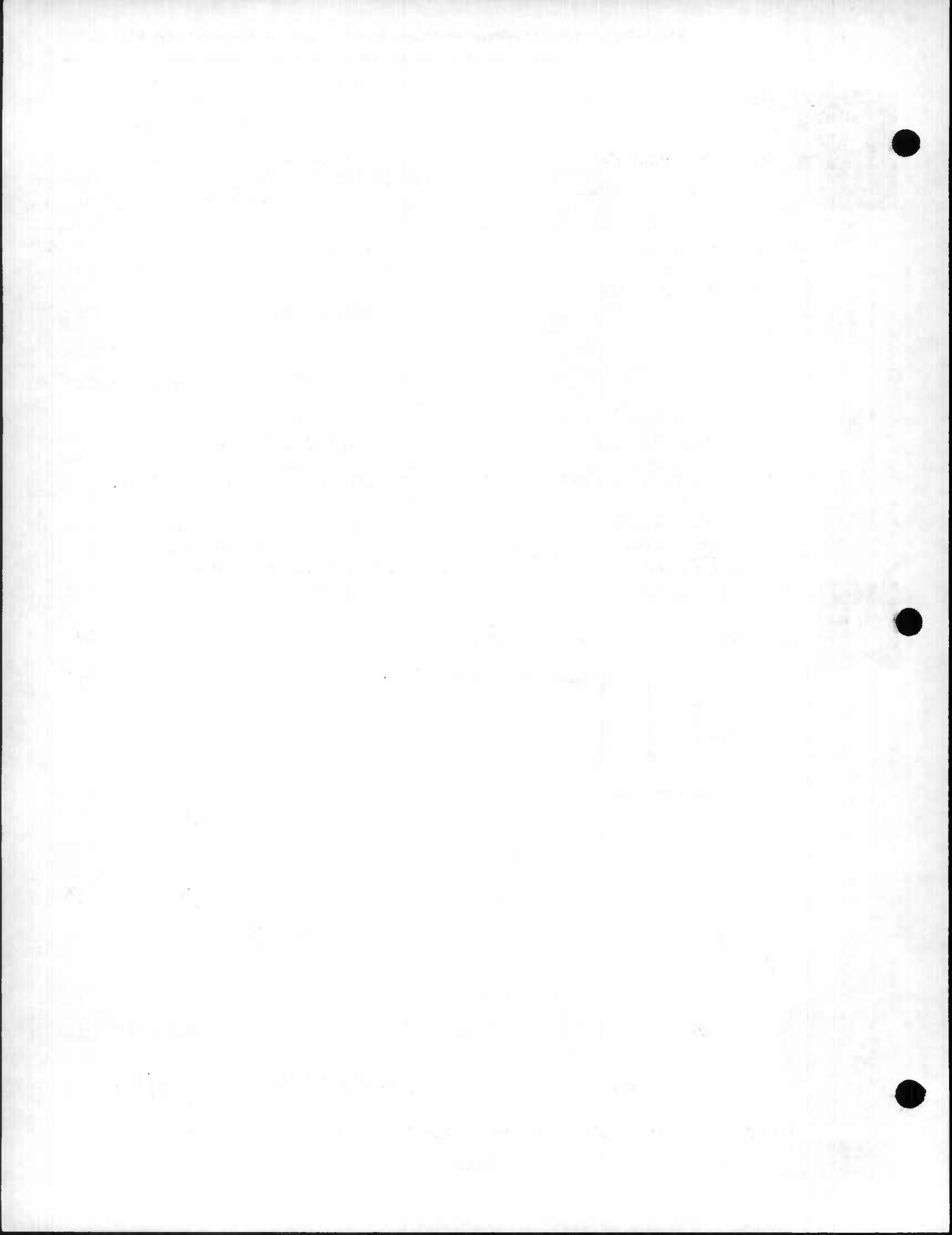
Reg. No.

87 39652

|   |   |   |   |  |  |  |   |  |  |  |   |                       |   |                                  |            |          |  |          |
|---|---|---|---|--|--|--|---|--|--|--|---|-----------------------|---|----------------------------------|------------|----------|--|----------|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>KRISTIN NICOLE RUPRECHT</b>  |   |   |  | 2. Date of Death<br>Month Day Year<br><b>DEC 14, 1997</b>  |  |   |  | 3. Time of Death<br><b>6:00 PM</b>   |  |   |                       |   |                                  |            |          |  |          |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>3009 BREEZEWOOD LANE</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>HAMPSTEAD</b>   |  |   |  | 4c. County of Death<br><b>CARROLL</b>  |  |   |                       |   |                                  |            |          |  |          |
| Funeral<br>Director   | 5. Social Security Number<br><b>220-25-2639</b>   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>8</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>NOV 9, 1989</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |  |   |                       |   |                                  |            |          |  |          |
|   | Usual Residence of Decedent   |   |   |  |  |  |   |  |  |  |   |                       |   |                                  |            |          |  |          |
| To Be Completed by Funeral Director   | 10a. State<br><b>MARYLAND</b>   |   | 10b. County<br><b>CARROLL</b>   |  | 10c. City, Town or Location<br><b>HAMPSTEAD</b>  |  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |   |                       |   |                                  |            |          |  |          |
|   | 10e. Street and Number<br><b>3009 BREEZEWOOD LANE</b>   |   |   |  | 10f. Zip Code<br><b>21074</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                 |  |  |  |   |                       |   |                                  |            |          |  |          |
|   | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |  |   |                       |   |                                  |            |          |  |          |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>STUDENT</b>  |  |   |  | 16b. Kind of Business/Industry<br><b>HAMPSTEAD ELEMENTARY SCHOOL</b>                               |  |   |                       |   |                                  |            |          |  |          |
|   | 17. Father's Name (First, Middle, Last)<br><b>TODD ALAN RUPRECHT</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>JULIE ANN SKEENS</b>   |  |   |  |  |  |   |                       |   |                                  |            |          |  |          |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>TODD A. RUPRECHT, FATHER</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3009 BREEZEWOOD LANE, HAMPSTEAD, MD 21074</b>  |  |   |  |  |  |   |                       |   |                                  |            |          |  |          |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CARROLL CREMATIONS</b>   |  | Date<br><b>12/18</b>   |  | 20c. Location - City or Town, State<br><b>HAMPSTEAD, MD</b> |  |  |  |   |                       |   |                                  |            |          |  |          |
|   | 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br><b>ELINE FUNERAL HOME</b><br><b>934 SOUTH MAIN ST, HAMPSTEAD, MD 21074</b>   |  |   |  |  |  |   |                       |   |                                  |            |          |  |          |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |  |  |  |   |  |  |  |   |                       |   |                                  |            |          |  |          |
|   | <table border="0"> <tr> <td rowspan="4">           Immediately list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a. <u>Dehydration</u></td> <td>Approximate Interval Between Onset and Death<br/><b>3d</b></td> </tr> <tr> <td>b. <u>Anaplastic Astrocytoma</u></td> <td><b>2yr</b></td> </tr> <tr> <td>c. _____</td> <td></td> </tr> <tr> <td>d. _____</td> <td></td> </tr> </table> |   |   |  |  |  |   |  |  |  | Immediately list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <u>Dehydration</u> | Approximate Interval Between Onset and Death<br><b>3d</b> | b. <u>Anaplastic Astrocytoma</u> | <b>2yr</b> | c. _____ |  | d. _____ |
| Immediately list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | a. <u>Dehydration</u>   | Approximate Interval Between Onset and Death<br><b>3d</b>   |   |  |  |  |   |  |  |  |   |                       |   |                                  |            |          |  |          |
|   | b. <u>Anaplastic Astrocytoma</u>  | <b>2yr</b>  |   |  |  |  |   |  |  |  |   |                       |   |                                  |            |          |  |          |
|   | c. _____  |   |   |  |  |  |   |  |  |  |   |                       |   |                                  |            |          |  |          |
|   | d. _____  |   |   |  |  |  |   |  |  |  |   |                       |   |                                  |            |          |  |          |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.  |   |   |   |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |   |                       |   |                                  |            |          |  |          |
|   |   |   |   |  |  |  |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   |                       |   |                                  |            |          |  |          |
|   |   |   |   |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |                       |   |                                  |            |          |  |          |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 28. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |   |  |  |  |   |                       |   |                                  |            |          |  |          |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>        |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |  |   |                       |   |                                  |            |          |  |          |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |   |  |  |  |   |                       |   |                                  |            |          |  |          |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |  |  |  |   |  |  |  |   |                       |   |                                  |            |          |  |          |
| 29b. Signature and title of certifier<br>   |   |   |   | 29c. License number<br><b>D0052777</b> |  | 29d. Date signed (Month, Day, Year)<br><b>12/15/97</b>                               |   |  |  |  |   |                       |   |                                  |            |          |  |          |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DAVID LOEB, M.D. 600 N Wolfe St CMSC-800 Baltimore MD 21287</b>  |   |   |   |  |  |  |   |  |  |  |   |                       |   |                                  |            |          |  |          |
| 31. Date filed (Month, Day, Year)<br><b>DEC 16 1997</b>   |   | 32. Registrar's Signature<br>   |   |  |  |  |   |  |  |  |   |                       |   |                                  |            |          |  |          |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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Amend #17,18, 12/17/97, BMW, Montg. Co per F.H. State of Maryland / Department of Health and Mental Hygiene **97 39653**  
**Certificate of Death** Reg. No.

|  |   |  |   |   |  |                                 |   |  |   |  |  |
|--|---|--|---|---|--|---------------------------------|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Clara K. Rosen</b>   |  |   |   | 2. Date of Death<br>Month <b>December</b> Day <b>13</b> , Year <b>1997</b>   |                                 |   |  | 3. Time of Death<br><b>7:05pm</b>                                       |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Mariner Health Care</b>  |  |   |   | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>   |                                 |   |  | 4c. County of Death<br><b>Montgomery</b>                                |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>578-20-8429</b>   |  | 8. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.   |                                 | If Under 1 Year<br>Months Days                          |  | If Under 24 Hrs.<br>Hours Min.  |  |  |
|  | 6. Date of Birth<br>(Month, Day, Year)<br><b>April 15, 1909</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Kiev, Russia</b>   |   | 10a. State<br><b>Maryland</b>  |                                 | 10b. County<br><b>Montgomery</b>                        |  | 10c. City, Town or Location<br><b>Rockville</b>                         |  |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent   |  |   |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |                                 |   |  |   |  |  |
|  | 10e. Street and Number<br><b>11410 Strand Drive</b>   |  |   |   | 10f. Zip Code<br><b>20852</b>  |                                 |   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |                                 |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>  |  | Collegia (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |                                 |   |  | 16b. Kind of Business/Industry<br><b>Own Home</b>                       |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><del>Shlomo</del> <b>Unknown</b>   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><del>Kaminsky</del> <b>Unknown</b>  |                                 |   |  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Jack Rosen /son</b>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11410 Strand Dr. Rockville, MD 20852</b>   |                                 |   |  |   |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Judean Memorial Gardens</b>  |   | Date<br><b>12/16/97</b>  |                                 | 20c. Location - City or Town, State<br><b>Olney, MD</b> |  |   |  |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  |   |   | 22. Name and Address of Facility<br><b>Ives-Pearson Funeral Homes</b><br><b>2847 Wilson Blvd. Arlington, VA 22201</b>  |                                 |   |  |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Alzheimer - Dementia</b><br>Due to (or as a consequence of):<br><br><b>b.</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b> |  |   |   | Approximate Interval Between Onset and Death<br><b>Years</b>   |                                 |   |  |   |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.  |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                 |   |  |   |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |                                 |   |  |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |   | 28. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |                                 |   |  |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   |  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b> |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   | 28d. Describe how injury occurred                      |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   | 29b. Signature and title of certifier<br>   |  |                                 |   | 29c. License number<br><b>Do8944</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>12/15/97</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Martin C. Shargel, M.D. 3720 Farragut Ave. Kensington, MD 20895-2110</b>  |   |  |   | 31. Date filed (Month, Day, Year)<br><b>DEC 17 1997</b>   |  |                                 |   | 32. Registrar's Signature<br>  |   |  |  |

Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39654

|  |  |   |  |   |  |  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>CLYDE WOODHAM ROBINSON</b>                    |   |  |   | 2. Date of Death<br>Month Day Year<br><b>DECEMBER 12, 1997</b> |  | 3. Time of Death<br><b>10:00 A.M.</b>  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>HOLY CROSS HOSPITAL</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>SILVER SPRING</b>   |  | 4c. County of Death<br><b>MONTGOMERY</b>   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>305-40-5421</b>  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                                 | 8. Date of Birth (Month, Day, Year)<br><b>DEC. 6, 1911</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>ALABAMA</b>                         |  |
|  | Usual Residence of Decedent  |   |  |   |  |  |  |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>MONTGOMERY</b>  |  | 10c. City, Town or Location<br><b>SILVER SPRING</b>   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 10e. Street and Number<br><b>1316 FENWICK LANE APT. 1308</b>   |  |   |  | 10f. Zip Code<br><b>20910</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br><b>WHITE</b><br>Specify:                       |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>+4</b> Collega (1-4 or 5+)   |  |   |  | 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>TEACHER</b>   |  |  | 16b. Kind of Business/Industry<br><b>EDUCATION</b>   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>TULLUS WOODHAM</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>BEUNA WARR</b>  |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>DR. VIRGIL ROBINSON HUSBAND</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1316 FENWICK LANE APT. 1308, SILVER SPRING, MD 20910</b>                                    |  |  |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MOUNT COMFORT CREMATORY</b> |   | Date<br><b>12/15/97</b>  |  | 20c. Location - City or Town, State<br><b>ALEXANDRIA, VA</b>                                     |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>JOSEPH GAWLER'S SONS, INC. 5130 WI AVENUE, N.W. WASHINGTON, D.C. 20016</b>   |  |  |  |  |  |
| 23a. Pertinent enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>CARDIAC ARRYTHMIA</b><br>Due to (or as a consequence of):<br>b. <b>VALVULAR HEART DISEASE, MITRAL REGURGITATION</b><br>Due to (or as a consequence of):<br>c. <b>AORTIC STENOSIS</b><br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  |   |  |  |  | Approximate Interval Between Onset and Death<br><b>MINUTES</b><br><br><b>YEARS</b> |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.<br><b>OSTEOPOROSIS</b>  |  |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |
|  |  |   |  |   |  | 24e. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |
|  |  |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br><b>D17423</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>12/14/97</b>   |  |  |  |
| 30. Name and address of person who completed causa of death (Item 23e) (Type, Print)<br><b>DEBORAH B. GOLDBERG, M.D. 8700 GEORGIA AVENUE #400, SILVER SPRING, MD 20910</b>   |  |   |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 15 1997</b>  |  | 32. Registrar's Signature<br>  |  |   |  |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transfer

CLEARED BY DR. TAUBER 12/12/97  
Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39655

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SARAH

ROSENTHAL

2. Date of Death

Month

Day

Year

DECEMBER 11, 1997

3. Time of Death

12:15pm

4a. Facility Name (If not institution, give street and number)

1316 Fenwick Lane #907

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

577-01-6975

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Feb 14, 1904

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1316 Fenwick Lane #907

10f. Zip Code

20910

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

George Seigel

18. Mother's Name (First, Middle, Maiden Surname)

Rebecca Weitz

19a. Informant's Name/Relationship (Type, Print)

Isadore Rosenthal-Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1316 Fenwick Lane #907 Silver Spring, MD 20910

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

King David Memorial Gar 12/14/97 Falls Church, VA

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

-Edward  
Sagel

22. Name and Address of Facility

Edward Sagel Funeral Direction  
1091 Rockville Pike Rockville, MD 2085223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Complications of Congestive Heart Failure several  
years

Renal Failure

Myelodysplastic Syndrome

Bone marrow

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☒ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Charles A. Abrams MD

29c. License number

6368

29d. Date signed (Month, Day, Year)

12/12/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DR. CHARLES ABRAMS 2141 KESH NW Suite 702 WASH DC 20007

31. Date filed (Month, Day, Year)

DEC 16 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

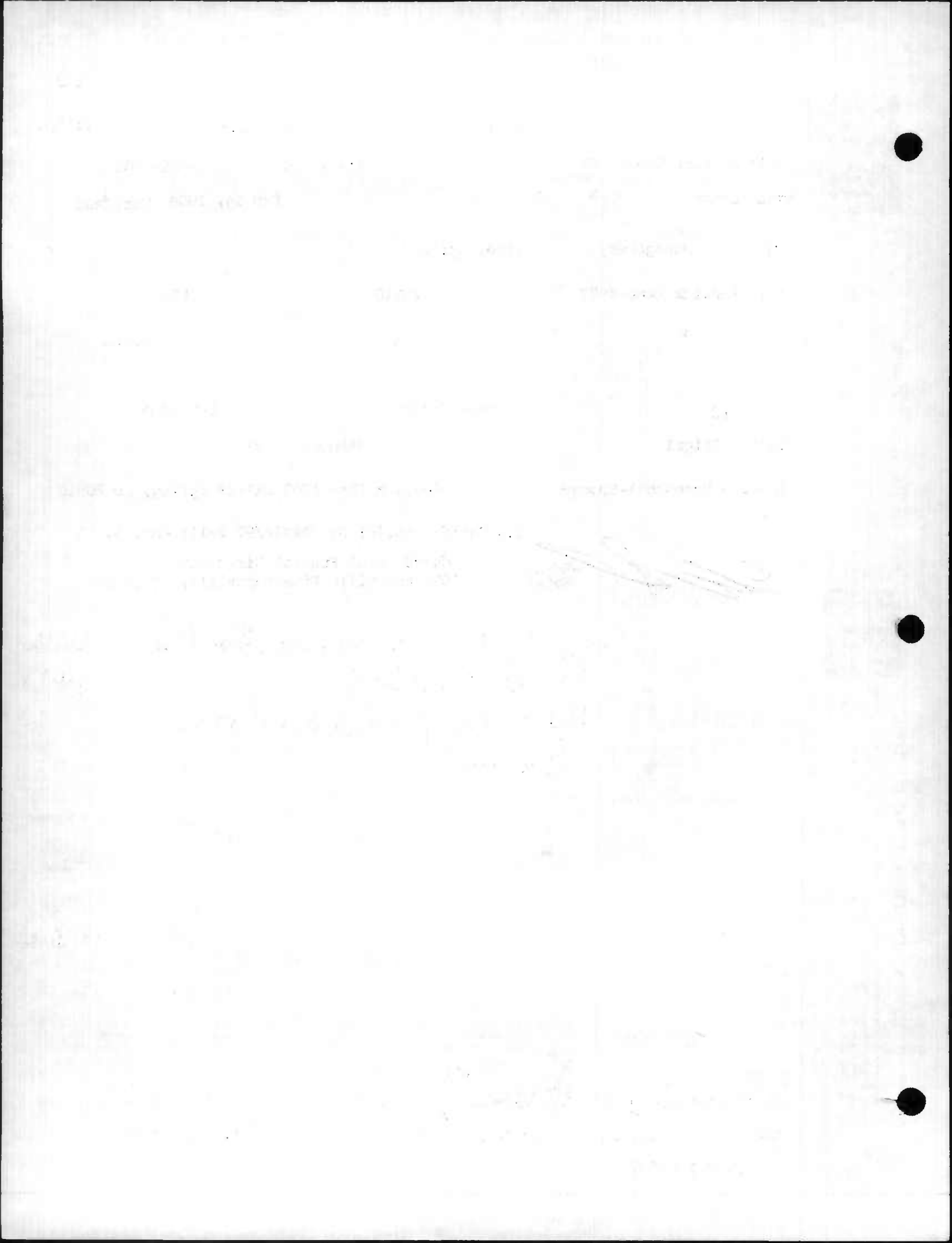
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39656

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Stuart E. Ross

2. Date of Death

Month Day Year  
December 14, 1997

3. Time of Death

5:00 PM

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

578-62-5342

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

50 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Aug. 6, 1947

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

938 Willowleaf Way

10f. Zip Code

20854

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Physician

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

Louis Ross

18. Mother's Name (First, Middle, Maiden Summa)

Ann Sakolsky

19a. Informant's Name/Relationship (Type, Print)

Sue Ross (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

938 Willowleaf Way, Rockville, Maryland 20854

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Comfort Crematory

Date

12-19-97

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature

Funeral Service License

22. Name and Address of Facility

Danzansky-Goldberg Mem. Chapels, Inc.  
1170 Rockville Pike, Rockville, MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Amyloidosis

Due to (or as a consequence of):

b. Renal Failure

Due to (or as a consequence of):

c. Coronary artery

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

37 YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEPSIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician

2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier

29c. License number

D 35635

29d. Date signed (Month, Day, Year)

December 15, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Kneum 18111 Prince Philip Dr Olney, MD 20832

31. Date filed (Month, Day, Year)

DEC 17 1997

32. Registrar's Signature

J. Davidson

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

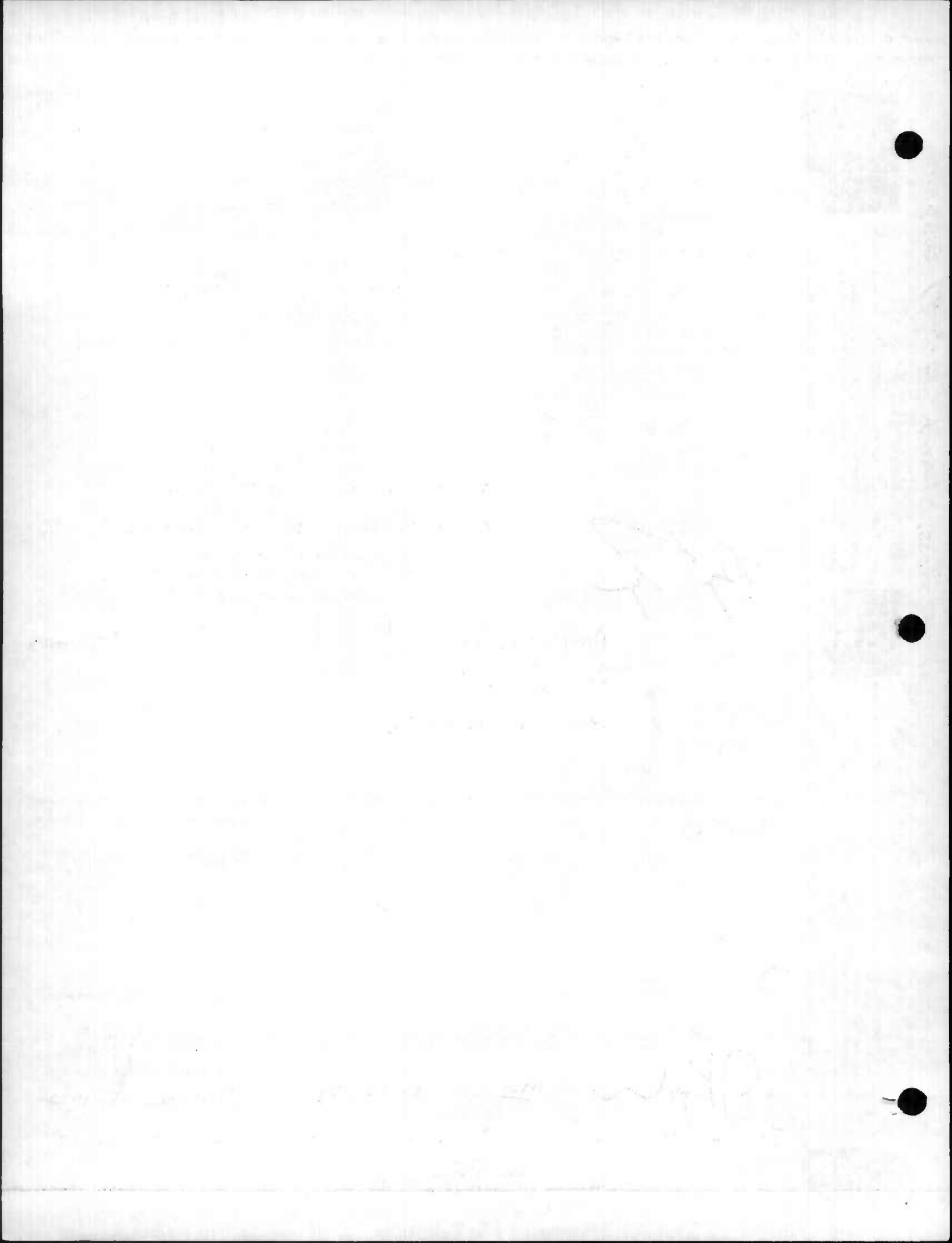
Ross, Stuart 12-14-97 5:50 PM

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 39657  
Certificate of Death

Reg. No.

|  |  |  |  |  |   |                          |                                |   |  |  |   |  |
|--|--|--|--|--|---|--------------------------|--------------------------------|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>RALPH HOWARD RUBEN   |  |  |  | 2. Date of Death<br>Month Day Year<br>December 17 1997  |                          |                                |   | 3. Time of Death<br>8:57 pm  |  |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>DOCTORS HOSPITAL OF PG COUNTY  |  |  |  | 4b. City, Town, or Location of Death<br>LANHAM  |                          |                                |   | 4c. County of Death<br>PRINCE GEORGES  |  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br>229-34-3524   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (in yrs. last birthday)<br>72 Yrs.   |                          | If Under 1 Year<br>Months Days |   | 8. Date of Birth (Month, Day, Year)<br>AUG 12 1925   |  | 9. Birthplace (State or Foreign Country)<br>VA                                      |  |
|  | Usual Residence of Decedent  |  |  |  |   |                          |                                |   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| To Be Completed by Funeral Director  | 10a. State<br>MD   |  | 10b. County<br>PRINCE GEORGES  |  | 10c. City, Town or Location<br>COLLEGE PARK   |                          |                                |   |  |  |   |  |
|  | 10e. Street and Number<br>6100 WESTCHESTER PARK DRIVE #1604  |  |  |  | 10f. Zip Code<br>20740  |                          |                                |   | 10g. Citizen of What Country?<br>UNITED STATES   |  |   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1944-<br>If Yes, Give Year or Dates: 1953 |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                          |                                |   | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE   |  |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 4   |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>ENGINEER   |                          |                                |   | 16b. Kind of Business/Industry<br>CONSTRUCTION   |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br>DAVID RUBEN   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>ANNA WOLFF   |                          |                                |   |  |  |   |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br>NINA RUBEN (WIFE)  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6100 WESTCHESTER PARK DR #1604, COLLEGE PARK MD 20740  |                          |                                |   |  |  |   |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>MT COMFORT CREMATORY  |                          | Data<br>12/22/97               |   | 20c. Location - City or Town, State<br>ALEXANDRIA, VA  |  |   |  |
|  | 21. Signature of Funeral Service Licensee  |  |  |  | 22. Name and Address of Facility<br>DANZANSKY-GOLDBERG MEMORIAL CHAPELS INC<br>1170 ROCKVILLE PIKE, ROCKVILLE MD 20852  |                          |                                |   |  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Myocardial Infarction<br>Due to (or as a consequence of):<br>b. Coronary Artery Disease<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |  |   |                          |                                |   |  |  | Approximate Interval Between Onset and Death<br>15 years                            |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Peripheral Vascular Disease<br>Prostatic Hypertrophy   |  |  |  |   |                          |                                |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> OOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |                          |                                |   |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  |  |  | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br>M |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred                        |   |  |
|  |  |  |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |                          |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. Signature and title of certifier  |   |                          |                                | 29c. License number<br>D31001   |  | 29d. Date signed (Month, Day, Year)<br>December 18, 1997 |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dr. Stuart Turkewitz, 7500 Greenway Center Drive, #430, Greenbelt, MD 20770  |  |  |  |  |   |                          |                                |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br>DEC 19 1997   |  |  |  | 32. Registrar's Signature<br>Julia Davidson-Randall  |   |                          |                                |   |  |  |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39658

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Gilda

Ruggieri

2. Date of Death

December 13, 1997

3. Time of Death

3:00 PM

4a. Facility Name (If not institution, give street and number)

6007 Riggs Road

4b. City, Town, or Location of Death

Hyattsville

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

214-74-5192

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

100 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 22, 1897

9. Birthplace (State or Foreign Country)

Italy

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6007 Riggs Road

10f. Zip Code

20783

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Pio Debuonaventura

18. Mother's Name (First, Middle, Maiden Surname)

Giacinta Costandino

19a. Informant's Name/Relationship (Type, Print)

Theresa Paull / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3716 Stoney Castle Street, Olney, Maryland 20832

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery 12/17/97 Silver Spring, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Alay Donnell

22. Name and Address of Facility

Hines-Rinaldi Funeral Home  
11800 New Hampshire Avenue  
Silver Spring, Maryland 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

Approximate Interval Between Onset and Death

1 YR

Due to (or as a consequence of):

b. AORTIC STENOSIS

1 YR

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☒ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

VP Singh Attend. Phys

29c. License number

D 19897

29d. Date signed (Month, Day, Year)

12.16.97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

V. SINGH 7209 A HANOVER PARKWAY GREEN BELT MD 20770

31. Date filed (Month, Day, Year)

DEC 18 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

COVERING DR ALISON.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39659

|   |  |  |   |   |   |  |  |  |
|---|--|--|---|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Fred H. Romer</b>                                     |  |   |   | 2. Date of Death<br>Month <b>December</b> Day <b>4</b> Year <b>1997</b> |  | 3. Time of Death<br><b>8:55AM</b>                          |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Anne Arundel Medical Center</b> |  |   |   | 4b. City, Town, or Location of Death<br><b>Annapolis</b>                |  | 4c. County of Death<br><b>Anne Arundel</b>                 |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>157-12-2067</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F<br><b>XX</b> |   | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.                        |  | 8. Date of Birth (Month, Day, Year)<br><b>July 26 1918</b> |  |
|   | Usual Residence of Decedent  |  | 9. Birthplace (State or Foreign Country)<br><b>New Jersey</b>                           |   | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Anne Arundel</b>                         |  |
| 10c. City, Town or Location<br><b>Edgewater</b>   |  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 10e. Street and Number<br><b>200 Cardamon Drive</b>  |  |  |
| 10f. Zip Code<br><b>11037</b>   |  |  |   | 10g. Citizen of What Country?<br><b>United States</b>   |   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |  |
| 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b>   |  |  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>   |  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Owner</b>   |   | 16b. Kind of Business/Industry<br><b>Mini Storage Company</b>  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Frederick A. Romer</b>  |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Agnes Marie Hendry</b>  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary E. Romer (Wife)</b>   |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>200 Cardamon Drive Edgewater, Maryland 21037</b>  |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Woodlawn Cemetery</b>  |   | 20c. Location - City or Town, State<br><b>Bronx, New York</b>  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Donald A. Taylor</i>  |  |  |   | 22. Name and Address of Facility<br><b>John M. Taylor Funeral Home, Inc.<br/>147 Duke of Gloucester St. Annapolis, MD 21401</b>   |   |  |  |  |
| 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>a. <b>Acute myocardial infarction</b><br>Due to (or as a consequence of):<br>b. <b>Coronary artery disease</b><br>Due to (or as a consequence of):<br>c. <b>Atherosclerosis</b><br>Due to (or as a consequence of):<br>d.<br>e. |  |  |   |   |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |   |   |   |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |   |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |   |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Congestive Heart Failure</b><br><b>Hypertension</b>  |  |  |   |   |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  |  |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   | 28d. Describe how Injury occurred   |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |   |   |   |  |  |  |
| 29b. Signature and title of certifier<br><i>Paul V. Beaks, MD</i>   |  |  |   | 29c. License number<br><b>025922</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>12/4/97</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Paul V. Beaks, MD, 9101 Chennysen, Laurel, MD 20688</b>  |  |  |   |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 10 1997</b>   |  |  |   | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>  |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transportation certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State  
Registrar

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the study and the objectives of the research. It also provides a brief overview of the methodology used in the study.

2. The second part of the report is a detailed description of the study area. It includes information about the location of the study area, the population of the study area, and the characteristics of the study area. It also discusses the data sources used in the study.

3. The third part of the report is a detailed description of the study results. It includes information about the findings of the study, the conclusions drawn from the findings, and the implications of the findings. It also discusses the limitations of the study and the need for further research.

4. The fourth part of the report is a conclusion and recommendations section. It summarizes the main findings of the study and provides recommendations for future research and policy. It also discusses the overall impact of the study and the need for further research.

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2. The second part of the report is a detailed description of the study area. It includes information about the location of the study area, the population of the study area, and the characteristics of the study area. It also discusses the data sources used in the study.

3. The third part of the report is a detailed description of the study results. It includes information about the findings of the study, the conclusions drawn from the findings, and the implications of the findings. It also discusses the limitations of the study and the need for further research.

4. The fourth part of the report is a conclusion and recommendations section. It summarizes the main findings of the study and provides recommendations for future research and policy. It also discusses the overall impact of the study and the need for further research.

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**

97 39660

Item:23b per MD G-755 1/23/98 dh

**Certificate of Death**

Reg. No.

|   |  |   |  |  |  |  |  |   |   |   |  |  |                |  |  |    |  |
|---|--|---|--|--|--|--|--|---|---|---|--|--|----------------|--|--|----|--|
| <b>Physician<br/>/Medical<br/>Examiner</b>  | 1. Decedent's Name (First, Middle, Last)<br><b>Virginia M. Rabbitt</b>                               |   |  |  | 2. Date of Death<br>Month <b>December</b> Day <b>12</b> , Year <b>1997</b> |  | 3. Time of Death<br><b>10:08PM</b>                         |   |   |   |  |  |                |  |  |    |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Doctors' Community Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Lanham</b>                      |  | 4c. County of Death<br><b>Prince George's</b>              |   |   |   |  |  |                |  |  |    |  |
| <b>Funeral<br/>Director</b>   | 5. Social Security Number<br><b>579 22 4071</b>  |   | 8. Sex<br><input checked="" type="checkbox"/> Male <input type="checkbox"/> Female | 7. Age (In yrs. last birthday)<br><b>72</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 5, 1925</b> | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>     |   |   |  |  |                |  |  |    |  |
|   | Usual Residence of Decedent  |   |  |  |  |  |  |   |   |   |  |  |                |  |  |    |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Prince George's</b>   |  | 10c. City, Town or Location<br><b>Bowie</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |   |   |  |  |                |  |  |    |  |
| 10e. Street and Number<br><b>12637 Safety Turn</b>  |  |   |  | 10f. Zip Code<br><b>20715</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |   |   |   |  |  |                |  |  |    |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |   |   |  |  |                |  |  |    |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary</b>  |  | 16b. Kind of Business/Industry<br><b>Civil Government (City of Bowie)</b>  |  |   |   |   |  |  |                |  |  |    |  |
| 17. Father's Name (First, Middle, Last)<br><b>Jesse Taylor Mower</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Eleanor Argent</b>   |  |  |  |   |   |   |  |  |                |  |  |    |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Carol Barr Daughter</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>13008 Marquette Lane Bowie Maryland 20715</b>  |  |  |  |   |   |   |  |  |                |  |  |    |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arlington National Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>Arlington Virginia</b>   |  |   |   |   |  |  |                |  |  |    |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Robert E. Evans Funeral Home, Inc.<br/>16000 Annapolis Rd. Bowie Md. 20715</b>  |  |  |  |   |   |   |  |  |                |  |  |    |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |  |  |  |  |   |   |   |  |  |                |  |  |    |  |
| <table border="0" style="width:100%;"> <tr> <td style="width:30%;">Immediate Cause (Final disease or condition resulting in death)</td> <td style="width:40%;">e. <b>Lower GI bleeding</b><br/>Due to (or as a consequence of):</td> <td style="width:30%;">Approximate Interval Between Onset and Death<br/><b>24 hrs</b></td> </tr> <tr> <td rowspan="3">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. <b>Congestive Heart Failure</b><br/>Due to (or as a consequence of):</td> <td><b>5 years</b></td> </tr> <tr> <td>c. <b>Sepsis</b><br/>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> |  |   |  |  |  |  |  | Immediate Cause (Final disease or condition resulting in death) | e. <b>Lower GI bleeding</b><br>Due to (or as a consequence of): | Approximate Interval Between Onset and Death<br><b>24 hrs</b> | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. <b>Congestive Heart Failure</b><br>Due to (or as a consequence of): | <b>5 years</b> | c. <b>Sepsis</b><br>Due to (or as a consequence of): |  | d. |  |
| Immediate Cause (Final disease or condition resulting in death)   | e. <b>Lower GI bleeding</b><br>Due to (or as a consequence of):                                      | Approximate Interval Between Onset and Death<br><b>24 hrs</b>   |  |  |  |  |  |   |   |   |  |  |                |  |  |    |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | b. <b>Congestive Heart Failure</b><br>Due to (or as a consequence of):                               | <b>5 years</b>  |  |  |  |  |  |   |   |   |  |  |                |  |  |    |  |
|   | c. <b>Sepsis</b><br>Due to (or as a consequence of):   |   |  |  |  |  |  |   |   |   |  |  |                |  |  |    |  |
|   | d.   |   |  |  |  |  |  |   |   |   |  |  |                |  |  |    |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes Mellitus</b>  |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |   |   |  |  |                |  |  |    |  |
|   |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |   |  |  |                |  |  |    |  |
|   |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |   |  |  |                |  |  |    |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |   |   |   |  |  |                |  |  |    |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |   |  |  |                |  |  |    |  |
|   |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred  |  |  |  |   |   |   |  |  |                |  |  |    |  |
|   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |   |   |   |  |  |                |  |  |    |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |  |  |  |   |   |   |  |  |                |  |  |    |  |
| 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br><b>52119</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>12/13/97</b>   |  |   |   |   |  |  |                |  |  |    |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SRIDHAR CHATRAATHI Suite 302; 8100 Good Luck Rd., LANHAM, MD 20706</b>   |  |   |  |  |  |  |  |   |   |   |  |  |                |  |  |    |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 17 1997</b>   |  | 32. Registrar's Signature<br>  |  |  |  |  |  |   |   |   |  |  |                |  |  |    |  |

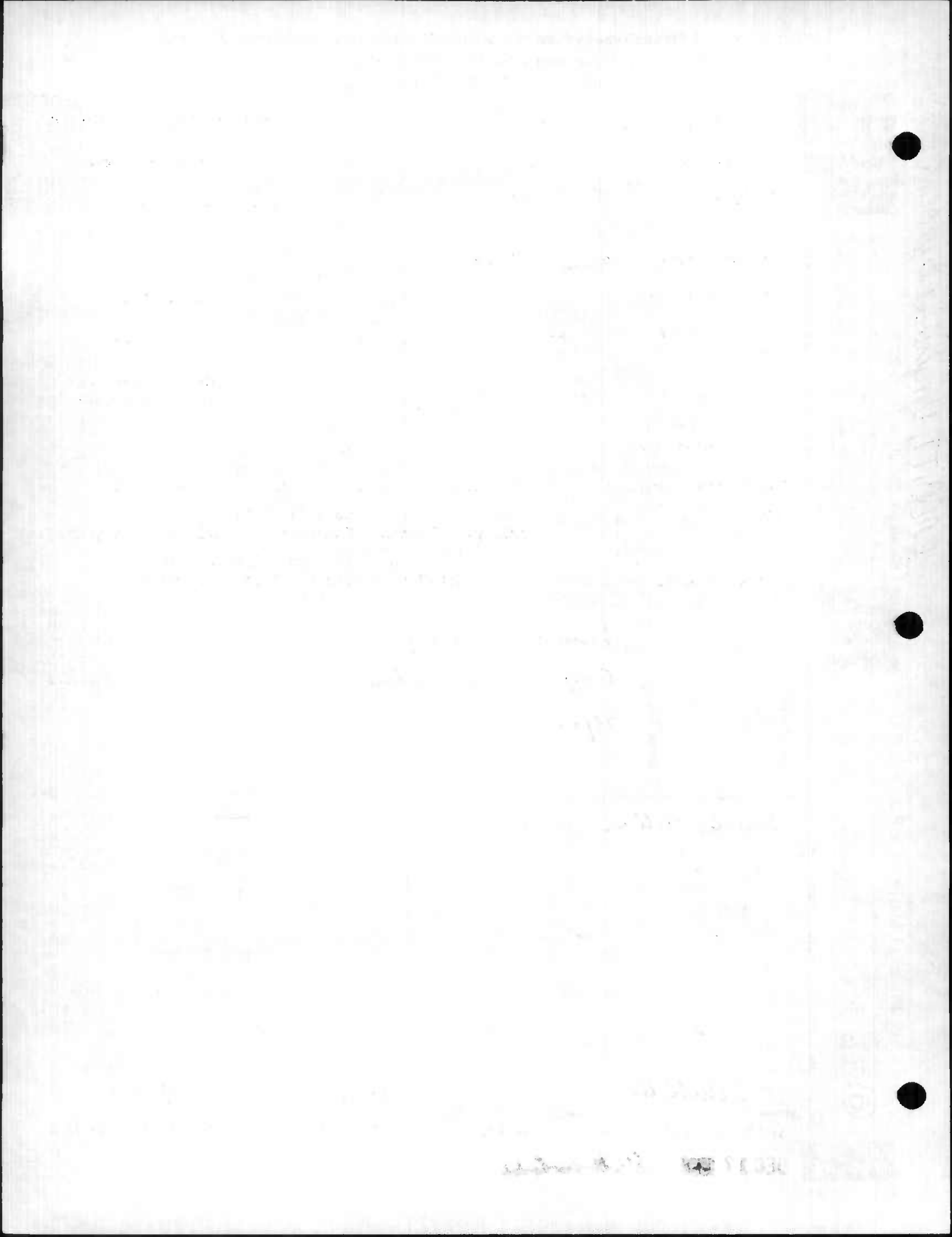
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: if item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 39661

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) Theresa Wiesmet Rosenberger  
2. Date of Death Month Day Year December 16, 1997  
3. Time of Death 7:35 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number) Villa Rosa Nursing Home  
4b. City, Town, or Location of Death Mitchellville  
4c. County of Death Prince George's

5. Social Security Number 189-48-5220  
6. Sex 1 ☐ M 2 ☒ F  
7. Age (In yrs. last birthday) 87 Yrs.  
8. Date of Birth (Month, Day, Year) Nov. 10, 1910  
9. Birthplace (State or Foreign Country) Germany

Usual Residence of Decedent  
10e. State Maryland  
10b. County Prince George's  
10c. City, Town or Location Fort Washington  
10d. Inside City Limits 1 ☐ Yes 2 ☒ No

10e. Street and Number 712 Carnoustie Lane  
10f. Zip Code 20744  
10g. Citizen of What Country? U.S.A.

11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced  
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No  
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:  
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)  
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker  
16b. Kind of Business/Industry At Home

17. Father's Name (First, Middle, Last) Hans Wiesmet  
18. Mother's Name (First, Middle, Maiden Surname) Rosina Stich

19a. Informant's Name/Relationship (Type, Print) Hildegard R. Droter/Daughter  
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 712 Carnoustie Ln., Ft. Washington, MD 20744

20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  
20b. Place of Disposition (Name of cemetery, crematory or other place) Alleghany Memorial Park  
20c. Location - City or Town, State Pittsburgh, PA

21. Signature of Funeral Service Licensee George P. Kalas  
22. Name and Address of Facility George P. Kalas Funeral Home  
6160 Oxon Hill Rd., Oxon Hill, MD 20745

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
23b. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. Atherosclerosis Years  
Due to (or as a consequence of):  
b. Alzheimers Disease Years  
Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  
23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No  
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No  
26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined  
28a. Date of Injury (Month, Day, Year)  
28b. Time of Injury M  
28c. Injury at Work? 1 ☐ Yes 2 ☒ No  
28d. Describe how injury occurred  
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Rakesh Arora, M.D.  
29c. License number D20108  
29d. Date signed (Month, Day, Year) 12/16/1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Rakesh Arora, M.D. 14300 Gallant Fox Ln., Bowie, MD 20715

31. Date filed (Month, Day, Year) DEC 18 1997  
32. Registrar's Signature

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

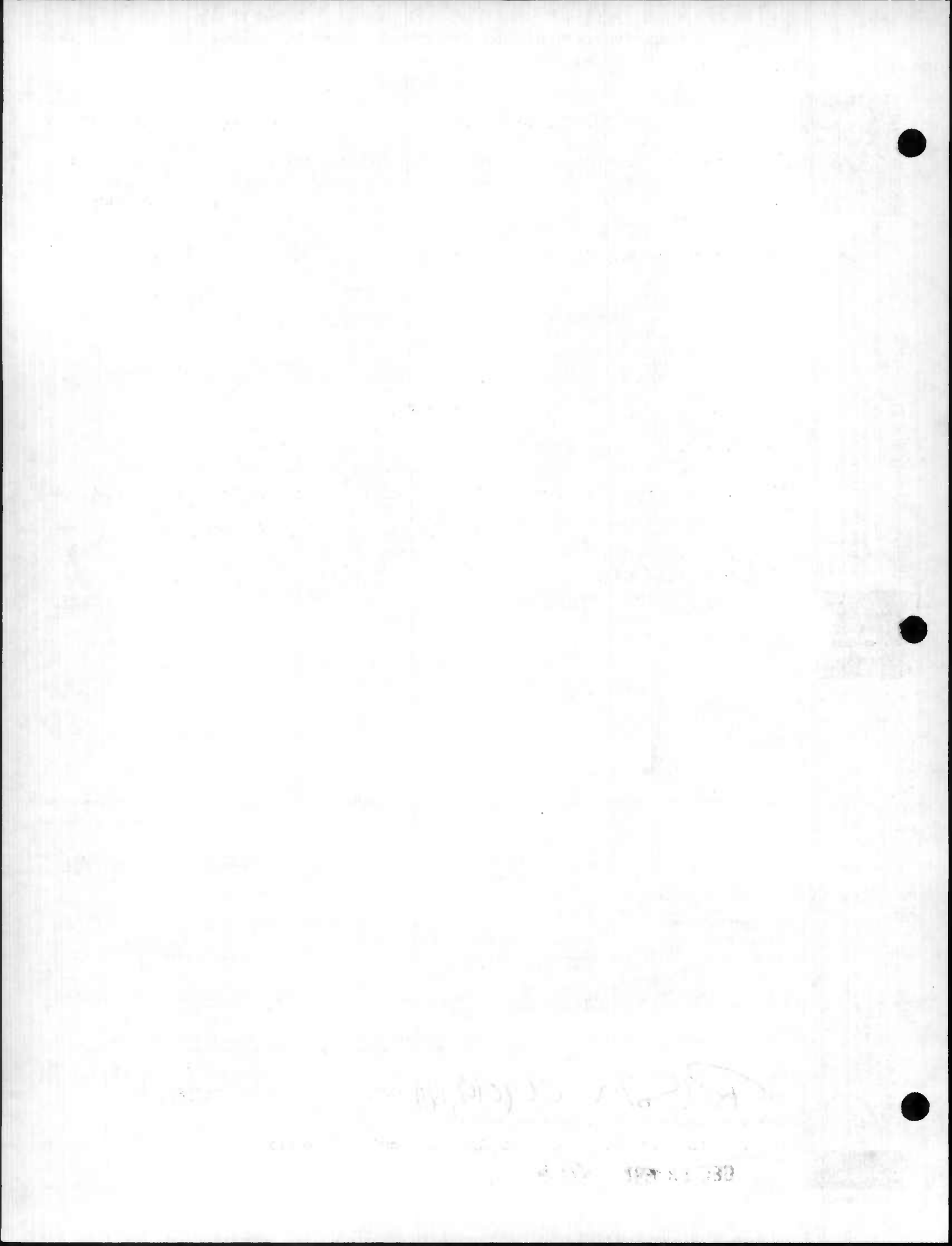
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39662

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Nancy Burke Reinitz

2. Date of Death

Month Day Year  
December 6, 1997

3. Time of Death

3:30 pm

4a. Facility Name (If not institution, give street and number)

1687 Secretariat Road

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

070-26-1156

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct 22, 1932

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1687 Secretariat Road

10f. Zip Code

21401

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Tax/Analyst

16b. Kind of Business/Industry

Internal Revenue  
Service

17. Father's Name (First, Middle, Last)

Walter

Burke

18. Mother's Name (First, Middle, Maiden Surname)

Elsie

O'Malley

19a. Informant's Name/Relationship (Type, Print)

Karl Reinitz/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

75 Sheridan Road, Arnold, MD 21012

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Lakemont Cemetery

Date

Dec 11  
1997

20c. Location - City or Town, State

Davidsonville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Barranco & Sons, P.A. Severna Park Funeral Home  
495 Gov. Ritchie Hwy., Severna Park, MD 2114623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Metastatic Melanoma  
Due to (or as a consequence of):Approximate  
interval between  
Onset and Death

15 years

Sequitally list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

038909

29d. Date signed (Month, Day, Year)

12/8/97

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

4940 Eicken Ave Baltimore Md 21224

William Sharfman, M.D.

31. Date filed (Month, Day, Year)

DEC 11 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39663

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mabel Smith Reynolds

2. Date of Death

Month 12 Day 13 Year 1997

3. Time of Death

22:15

4a. Facility Name (If not institution, give street and number)

Harford Memorial Hospital

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

236-10-8223

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
05/04/1914

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Havre de Grace

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

935 Drew Drive

10f. Zip Code

21078

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
11th

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Clarence T. Evans

18. Mother's Name (First, Middle, Maiden Surname)

Ida Bell Smith

19a. Informant's Name/Relationship (Type, Print)

Nell Husfelt- sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19 Norman Allen St. Elkton, MD 21921

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Principio Cemetery

Date

12/17/97

20c. Location - City or Town, State

Principio, MD

21. Signature of Funeral Service Licensee

George M. Hampton Jr.

22. Name and Address of Facility

Mitchell-Smith Funeral Home, P.A.  
123 S. Washington St. Havre de Grace, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

one week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Pneumonia

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

C. Bowman MD

29c. License number

D42934

29d. Date signed (Month, Day, Year)

14, December 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Carol Bowman Harford Memorial Hospital, Havre de Grace, MD

31. Date filed (Month, Day, Year)

DEC 16 1997

32. Registrar's Signature

John A. Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Amended #3 12-19-97 HCHD CAS

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39664

Physician  
/Medical  
Examiner

1. Decedant's Name (First, Middle, Last)

JOHN CHARLES REMBOLD

2. Date of Death

December 10, 1997

3. Time of Death  
9:45 PM

4a. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

220-01-6339

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 10, 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedant

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Jarrettsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2901 Calliston Court

10f. Zip Code

21084

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedant Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII

13. Was Decedant of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedant's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2

16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Engineer

16b. Kind of Business/Industry

Railroad

17. Father's Name (First, Middle, Last)

John Frederick Rembold

18. Mother's Name (First, Middle, Maiden Surname)

Jennie Estella Charles

19a. Informant's Name/Relationship (Type, Print)

Phyllis E. Rembold, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2901 Calliston Court, Jarrettsville, Maryland 21084

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cokesbury UM Cemetery

Date

12/15/97

20c. Location - City or Town, State

Abingdon, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Howard K. McComas III Funeral Home, P.A.  
50 W. Broadway St., Bel Air, Maryland 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accidental 3 ☐ Suicidal 4 ☐ Homicidal  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D52025

29d. Date signed (Month, Day, Year)

12/10/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark Lott MD Fallston General Hospital 200 Milton Ave Fallston MD

31. Date filed (Month, Day, Year)

DEC 16 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 39665

|                                     |  |  |  |  |  |  |  |  |   |  |
|-------------------------------------|--|--|--|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Virgie Clyde Roe   |  |  |  |  |  | 2. Date of Death<br>Month Day Year<br>Dec 14 1997  |  | 3. Time of Death<br>2:20 PM   |  |
|                                     | 4a. Facility Name (If not institution, give street and number)<br>Mariner Health of Bel Air  |  |  |  |  |  | 4b. City, Town, or Location of Death<br>Bel Air  |  | 4c. County of Death<br>Harford  |  |
| Funeral<br>Director                 | 5. Social Security Number<br>233-07-9493   |  | 8. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br>89 Yrs.  |  | If Under 1 Year<br>Months Days   |  | If Under 24 Hrs.<br>Hours Min.  |  |
|                                     | 6. Date of Birth (Month, Day, Year)<br>November 28, 1908   |  | 9. Birthplace (State or Foreign Country)<br>West Virginia  |  | 10. Usual Residence of Decedent<br>10a. State: Maryland 10b. County: Harford 10c. City, Town or Location: Churchville  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |
| To Be Completed by Funeral Director | 10e. Street and Number<br>3053 Churchville Rd.   |  | 10f. Zip Code<br>21028   |  | 10g. Citizen of What Country?<br>USA   |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
|                                     | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12): 7 College (1-4 or 5+)  |  | 16. Kind of Business/Industry<br>Own Home  |  | 17. Father's Name (First, Middle, Last)<br>John Wesley Hart   |  |
|                                     | 18. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker  |  | 19. Mother's Name (First, Middle, Maiden Surname)<br>Melissa (U/K) Brown   |  | 20. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  | 21. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3000 Churchville Rd., Churchville, MD 21028  |  | 22. Name and Address of Facility<br>Howard K. McComas III Funeral Home, P.A.<br>50 W. Broadway & Williams Street, Bel Air, MD                         |  |
|                                     | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Pneumonia<br>Due to (or as a consequence of): |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                 |  |
|                                     | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)                          |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
|                                     | 28d. Describe how injury occurred  |  | 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>Scott Howell MD  |  |
|                                     | 29c. License number<br>D34652  |  | 29d. Date signed (Month, Day, Year)<br>December 15, 1997   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Scott Howell 2 North Avenue Bel Air Maryland 21014   |  | 31. Data filed (Month, Day, Year)<br>DEC 16 1997   |  | 32. Registrar's Signature<br>[Signature]  |  |
|                                     | 33. State Registrar  |  |  |  |  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39666

|   |   |  |   |   |  |                          |  |  |  |  |  |  |  |  |   |
|---|---|--|---|---|--|--------------------------|--|--|--|--|--|--|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><i>Thelma Marie Rice</i>  |  |   |   | 2. Date of Death<br>Month <i>Dec.</i> Day <i>4</i> Year <i>1997</i>  |                          |  |  | 3. Time of Death<br><i>8:30 A.M.</i>   |  |  |  |  |  |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><i>Williamsport Nursing Home</i>  |  |   |   | 4b. City, Town, or Location of Death<br><i>Williamsport</i>  |                          |  |  | 4c. County of Death<br><i>Washington</i>   |  |  |  |  |  |   |
| Funeral<br>Director   | 5. Social Security Number<br><i>220-16-3312</i>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (in yrs. last birthday)<br><i>82</i> Yrs.   |                          | If Under 1 Year<br>Months Days   |  | If Under 24 Hrs.<br>Hours Min.   |  | 8. Date of Birth<br>(Month, Day, Year)<br><i>July 11, 1915</i>   |  | 9. Birthplace (State or Foreign Country)<br><i>Maryland</i>  |  |   |
|   | Usual Residence of Decedent   |  |   |   |  |                          |  |  |  |  |  |  |  |  |   |
| To Be Completed by Funeral Director   | 10a. State<br><i>Md.</i>  |  | 10b. County<br><i>Washington</i>  |   | 10c. City, Town or Location<br><i>Hagerstown</i>   |                          |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |  |  |  |   |
|   | 10e. Street and Number<br><i>141 W. Franklin St.</i>  |  |   |   | 10f. Zip Code<br><i>21740</i>  |                          |  |  | 10g. Citizen of What Country?<br><i>U.S.A.</i>   |  |  |  |  |  |   |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                          |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i>                        |  |  |  |  |  |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+)  |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Machine Operator</i>   |                          |  |  | 16b. Kind of Business/Industry<br><i>Shoe Co.</i>  |  |  |  |  |  |   |
|   | 17. Father's Name (First, Middle, Last)<br><i>William Daniel Rice</i>   |  |   |   |  |                          | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Fannie R. Lamp</i> |  |  |  |  |  |  |  |   |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><i>Lorraine Smith (Daughter)</i>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>16 N. Antietam St. P.O. Box 376 Funkstown, Md. 21734</i>                                     |                          |  |  |  |  |  |  |  |  |   |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Smithsburg Crematory</i>  |                          |  |  | Date<br><i>Dec. 5, 1997</i>  |  | 20c. Location - City or Town, State<br><i>Smithsburg, Md.</i>  |  |  |  |   |
|   | 21. Signature of Funeral Service Licensee<br><i>Jenniss L. Davis</i>  |  |   |   | 22. Name and Address of Facility<br><i>Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783</i>  |                          |  |  |  |  |  |  |  |  |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <i>SEPTIC SHOCK</i><br>Due to (or as a consequence of):<br><br>b. <i>OPEN CHEST WOUND</i><br>Due to (or as a consequence of):<br><br>c. <i>BREAST SURGERY WOUND DEHISCENCE</i><br>Due to (or as a consequence of):<br><br>d. <i>SEVERE PERIPHERAL VASCULAR DISEASE</i><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |                          |  |  |  |  |  |  | Approximate Interval Between Onset and Death<br><br><i>3 HOURS</i><br><br><i>3 WEEKS</i><br><br><i>4 WEEKS</i><br><br><i>YEARS</i> |  |   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><i>SEVERE CHRONIC OBSTRUCTIVE PULMONARY DISEASE, CHRONIC ALCOHOL ABUSE</i>  |  |   |   |  |                          |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                          |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   | 28. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                          |  |  |  |  |  |  |  |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   |  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred                              |  |  |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   | 29b. Signature and title of certifier<br><i>Ted E. Howe MD</i>  |  |                          |  | 29c. License number<br><i>D33700</i>   |  | 29d. Date signed (Month, Day, Year)<br><i>December 4, 1997</i> |  |  |  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Ted E. Howe, M.D. 7542 Overlook Drive Boonsboro, MD 21713</i>  |   |  |   |   |  |                          |  |  |  |  |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><i>DEC 05 1997</i>   |   |  |   | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>  |  |                          |  |  |  |  |  |  |  |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39667

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>David Gerald REESE</b>  |  |   |  | 2. Date of Death<br>Month <b>December</b> Day <b>7</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>10 PM</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>7205 Linganore Road</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Frederick</b>  |  | 4c. County of Death<br><b>Frederick</b>  |  |
| 5. Social Security Number<br><b>215-20-8087</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>March 3, 1928</b>  |  |
| 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Frederick</b>   |  | 10c. City, Town or Location<br><b>Frederick</b>  |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>7205 Linganore Road</b>  |  | 10f. Zip Code   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1950-53</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Senior Field Representative</b>   |  | 16b. Kind of Business/Industry<br><b>business forms</b>   |  | 16c. College (1-4 or 5+)<br><b>4</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Ephraim Gerald Reese</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Hazel Marie George</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Stephen Reese - son</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2042 Red River Rd., Eldersburg, Md. 21784</b>   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Rose Hill Cemetery</b>   |  | Date<br><b>12-10-97</b>   |  | 20c. Location - City or Town, State<br><b>Hagerstown, Maryland</b>   |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>MINNICH FUNERAL HOME</b><br><b>415 E. Wilson Blvd., Hagerstown, Md. 21740</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. LUNG CANCER</b>  |  |   |  |   |  | Approximate Interval Between Onset and Death<br><b>1 YR</b>  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>a. Due to (or as a consequence of):</b>   |  |   |  |   |  |  |  |
| <b>b. Due to (or as a consequence of):</b>   |  |   |  |   |  |  |  |
| <b>c. Due to (or as a consequence of):</b>   |  |   |  |   |  |  |  |
| <b>d. Due to (or as a consequence of):</b>   |  |   |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  |  |   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D 21936</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>12-9-97</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>A. DONELSON MD 915 TOLLHOUSE #203 FREDERICK MD 21701</b>  |  |   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 10 1997</b>  |  | 32. Registrar's Signature<br>  |  |   |  |  |  |

State Registrar

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |  |   |  |
|--|--|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>CURTIS RICHMOND  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>December 8, 1997  |  |  |  | 3. TIME OF DEATH<br>11:43 P M   |  |
| 4. SOCIAL SECURITY NUMBER<br>233-46-3571   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>66 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>October 21, 1931                           |  | 8. BIRTHPLACE (State or Foreign Country)<br>West Virginia   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Washington County Hospital   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Hagerstown   |  |  |  | 9c. COUNTY OF DEATH<br>Washington   |  |
| RESIDENCE OF DECEDENT  |  |   |  |   |  |  |  |   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Washington   |  | 10c. CITY, TOWN OR LOCATION<br>Hagerstown   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br>208 East Franklin Street   |  |   |  | 10f. ZIP CODE<br>21740  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>Korean Conflict   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (14 or 5+) —   |  |   |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Carpenter  |  | 15b. KIND OF BUSINESS/INDUSTRY<br>Construction Company                               |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Jonah Joseph Richmond   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Rhoda May Bennett  |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mary V. Richmond   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>208 East Franklin Street, Hagerstown, Md. 21740  |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Greenlawn Memorial Park 12-12-97   |  |   |  | 20c. LOCATION — City or Town, State<br>Williamsport, Maryland                        |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>R. Paul Brady   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Andrew K. Coffman Funeral Home, Inc.<br>40 E. Antietam Street, Hagerstown, Md. 21740  |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Heart Disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. AND Chronic Obstructive Pulmonary Disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  |  |  | Approximate Interval Between Onset and Death<br>years   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |   |  |   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Edward W. Ditto, III  |  |   |  | 29c. LICENSE NUMBER<br>DO1062   |  | 29d. DATE SIGNED (Month, Day, Year)<br>December 10, 1997                             |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Edward W. Ditto, III, M.D. 217 W. Washington St. Hagerstown, MD 21740   |  |   |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>DEC 11 1997   |  |   |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randall  |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39669

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EDWARD RUSSEL RAYMOND

2. Date of Death

DEC 9 1997

3. Time of Death

8:55

4a. Facility Name (If not institution, give street and number)

WASHINGTON COUNTY HOSPITAL

4b. City, Town, or Location of Death

HAGERSTOWN

4c. County of Death

WASHINGTON

5. Social Security Number

216-22-1878

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

FEB. 16, 1927

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WASHINGTON

10c. City, Town or Location

HAGERSTOWN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10928 HOLLY TERRACE

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 21 Years

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

COMMAND SERGEANT MAJOR

16b. Kind of Business/Industry

U.S. ARMY, MILITARY

17. Father's Name (First, Middle, Last)

HENRY RUSSEL RAYMOND

18. Mother's Name (First, Middle, Maiden Surname)

LORETTA FAUTH

19a. Informant's Name/Relationship (Type, Print)

IRIS B. RAYMOND/SPOUSE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10928 HOLLY TERRACE, HAGERSTOWN, MARYLAND 21740

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SMITHSBURG CREMATORY

Date

12/9/97

20c. Location - City or Town, State

SMITHSBURG, MARYLAND

21. Signature of Funeral Service Licensee

Paul M. Dean

22. Name and Address of Facility

BAST FUNERAL HOME

7606 Old National Pike

Boonsboro, Maryland 21713

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Lung Cancer

Approximate Interval Between Onset and Death

1 year

e. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Intestinal Hemorrhage

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Frederic H. Kress III

29c. License number

223023

29d. Date signed (Month, Day, Year)

10/5/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Frederic H. Kress III 11110 Medical Campus Dr Hagerstown

31. Date filed (Month, Day, Year)

DEC 10 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



97 39670

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>LYNFORD CECIL RIDENOUR   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>December 12, 1997  |  | 3. TIME OF DEATH<br>10:30 A M  |  |
| 4. SOCIAL SECURITY NUMBER<br>214-09-0503   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>82 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>April 18, 1915  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Mt. Lena, Maryland   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>718 Chestnut Street  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Hagerstown  |  |
| 9c. COUNTY OF DEATH<br>Washington  |  |  |  | 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Washington  |  |
| 10c. CITY, TOWN OR LOCATION<br>Hagerstown  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>718 Chestnut Street  |  |
| 10f. ZIP CODE<br>21740   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>1942-1946  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: White   |  |  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0   |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Bonding Technician   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Aircraft Manufacturer  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>David Ridenour  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Minnie Bowman   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Ruth Ann Barron, Daughter  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>533 Reynolds Avenue, Hagerstown, Maryland 21740   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Rest Haven Cemetery 12/16   |  |  |  |
| 20c. LOCATION — City or Town, State<br>Hagerstown, Maryland  |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Kelly C. Fyanker</i>   |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br>Douglas A. Fiery Funeral Home<br>331 Eastern Blvd. N., Hagerstown, Maryland  |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardio Vascular Disease years<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. AND Chronic Obstructive Pulmonary Disease years<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)<br>28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>28d. DESCRIBE NOW INJURY OCCURRED<br>28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Edward W. Ditto, III</i>   |  |  |  |
| 29c. LICENSE NUMBER<br>D01062  |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br>December 12, 1997   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Print)<br>Edward W. Ditto, III, M.D. 217 W. Washington St. Hagerstown, Md 21740   |  |  |  | 31. DATE FILED (Month, Day, Year)<br>DEC 16 1997   |  |  |  |
| 32. REGISTRAR'S SIGNATURE<br><i>Johanna Davidson-Randall</i>   |  |  |  |  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



WRC  
97-7061-005  
WILLIAM G.  
SHEFFIELD

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39671

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |   |  |  |  |
|--|--|---|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>WILLIAM G. SHEFFIELD</b>  |  |   | 2. Date of Death<br>Month <b>DEC.</b> Day <b>07</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>5:00 PM.</b>                                    |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>RT. 30 AND FRINGER RD.</b>  |  |   | 4b. City, Town, or Location of Death<br><b>REISTERSTOWN</b>   |  | 4c. County of Death<br><b>BALTIMORE</b>                                |  |
| 5. Social Security Number<br><b>217-40-0655</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>56</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>May 18 1941</b>  |
| 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |   |   |  |  |  |
| Usual Residence of Decedent  |  |   |   |  |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Carroll</b>   |   | 10c. City, Town or Location<br><b>Sykesville</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 10e. Street and Number<br><b>2008 Sherryl Avenue</b>   |  |   | 10f. Zip Code<br><b>21784</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>                            |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1959-1965</b>  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Captain</b>  |  |   | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Captain</b>                    |  | 17. Kind of Business/Industry<br><b>Baltimore City Fire Department</b> |  |
| 17. Father's Name (First, Middle, Last)<br><b>William B. Sheffield</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Dorothy E.</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Patricia A. Prince (daughter)</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2010 Sherryl Ave. Sykesville MD 21784</b> |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lake View Memorial Park</b>  |   | Date<br><b>12/12/97</b>  | 20c. Location - City or Town, State<br><b>Sykesville MD</b>            |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   | 22. Name and Address of Facility<br><b>Haight Funeral Home &amp; Chapel<br/>P.O. Box 195 Sykesville MD 21784</b>                              |  |  |  |
| 23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. Multiple Injuries</b><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>f. Roadway</b><br>Due to (or as a consequence of):<br>g.<br>Due to (or as a consequence of):<br>h.<br>Due to (or as a consequence of): |  |   |   |  |  | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>ROAD</b> |   |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)<br><b>12-7-97</b>  |   | 28b. Time of Injury<br><b>16 50 M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Roadway</b>   |  | 28d. Describe how injury occurred<br><b>Driver auto - auto collision</b>  |   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>RT 30.</b>  |  |   |   |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |   |  |  |  |
| 29b. Signature and title of certifier<br>  |  |   | 29c. License number<br><b>O.C.M.E.</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>DEC. 08, 1997</b>            |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>   |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 15 1997</b>  |  | 32. Registrar's Signature<br>   |   |  |  |  |

State  
Registrar



093

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item #26, Per Phy.  
12/16/97, Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

39672

Physician  
/Medical  
Examiner

Funeral  
Director

|  |  |   |  |  |                                |   |  |
|--|--|---|--|--|--------------------------------|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Mary Leigh Stull</b>  |  |   |  | 2. Date of Death<br>Month <b>Dec.</b> Day <b>15</b> Year <b>1997</b>   |                                | 3. Time of Death<br><b>09:36</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Carroll County General Hospital</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Westminster</b>   |                                | 4c. County of Death<br><b>Carroll County</b>  |  |
| 5. Social Security Number<br><b>212-58-9155</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>49</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>March 8, 1948</b>   |  |
| 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |   |  |  |                                |   |  |
| Usual Residence of Decedent  |  |   |  |  |                                |   |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Carroll</b>   |  | 10c. City, Town or Location<br><b>Woodbine</b>   |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 10e. Street and Number<br><b>1126 Hoods Mill Road</b>  |  |   |  | 10f. Zip Code<br><b>21797</b>  |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary</b>  |                                | 16b. Kind of Business/Industry<br><b>Clerical</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Harry Otis Bopst</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anna Lorraine Ways</b>   |                                |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. Emory N. Stull, Jr. (Husband)</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1126 Hoods Mill Road Woodbine, MD 21797</b>  |                                |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Springfield Cemetery</b>   |  | Date<br><b>12/ 18/97</b>   |                                | 20c. Location - City or Town, State<br><b>Sykesville, MD</b>  |  |
| 21. Signature of Funeral Service Licensee<br><b>Brian L. Haight</b>  |  |   |  | 22. Name and Address of Facility<br><b>HAIGHT FUNERAL HOME &amp; CHAPEL (Box 195)<br/>Sykesville, MD 21784 (410)-795-1400</b>  |                                |   |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Acute Aspiration</b><br>Due to (or as a consequence of):<br><b>b. Vomiting</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |   |  | Approximate Interval Between Onset and Death<br><b>Immediate</b><br><b>Minutes</b>   |                                |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cancer</b><br><b>Chemotherapy</b>   |  |   |  |  |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> OOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 28d. Describe how injury occurred  |  |   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |                                |   |  |
| 28f. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |  |                                |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |                                |   |  |
| 29b. Signature and title of certifier<br><b>David J. Kahan, MD</b>   |  |   |  | 29c. License number<br><b>D35572</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>December 15, 1997</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>David J. Kahan, M.D., Carroll County General Hospital, 200 Memorial Ave.</b>  |  |   |  |  |                                |   |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 16 1997</b>  |  |   |  | 32. Registrar's Signature<br><b>J. A. Anderson-Randall</b>   |                                |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

1000

1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item #26, Per M.E.  
12/16/97, Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

97 39673

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EVELYN CATHERINE SHEFFIELD

2. Date of Death

December 7, 1997

Day Year

3. Time of Death

5 PM

4a. Facility Name (not institution, give street and number)

RT. 30 and Fringer Road

4b. City, Town, or Location of Death

Reisterstown

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

218-36-7797

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

57 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 15 1940

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

MD

10b. County

Carroll

10c. City, Town or Location

Sykesville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2008 Sherryl Avenue

10f. Zip Code

21784

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

August Herrmann

18. Mother's Name (First, Middle, Maiden Summa)

Mary Margaret Ganley

19a. Informant's Name/Relationship (Type, Print)

Patricia A. Prince (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2010 Sherryl Avenue, Sykesville MD 21784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lake View Memorial Park

Date

12/12/97

20c. Location - City or Town, State

Sykesville MD

21. Signature of Funeral Service Licensee

Brian L. Hight

22. Name and Address of Facility

Haight Funeral Home & Chapel  
P.O. Box 195 Sykesville MD 21784

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Multiple Body Injuries  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 8 ☒ Other (Specify) Roadway

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

December 7, 1997

28b. Time of Injury

5 PM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Collision with oncoming automobile

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Roadway

28f. Location (Street and Number or Rural Route Number, City or Town, State)

RT 30 + Fringer Road - Reisterstown Maryland

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

B. Williamson M.D.

29c. License number

D11171

29d. Date signed (Month, Day, Year)

December 10, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

E.P. Williams 405 Frederick Ave CATONSVILLE 21225 MARYLAND

31. Date filed (Month, Day, Year)

DEC 16 1997

32. Registrar's Signature

J. Davidson

State  
Registrar

Baltimore, Maryland 21215-0020

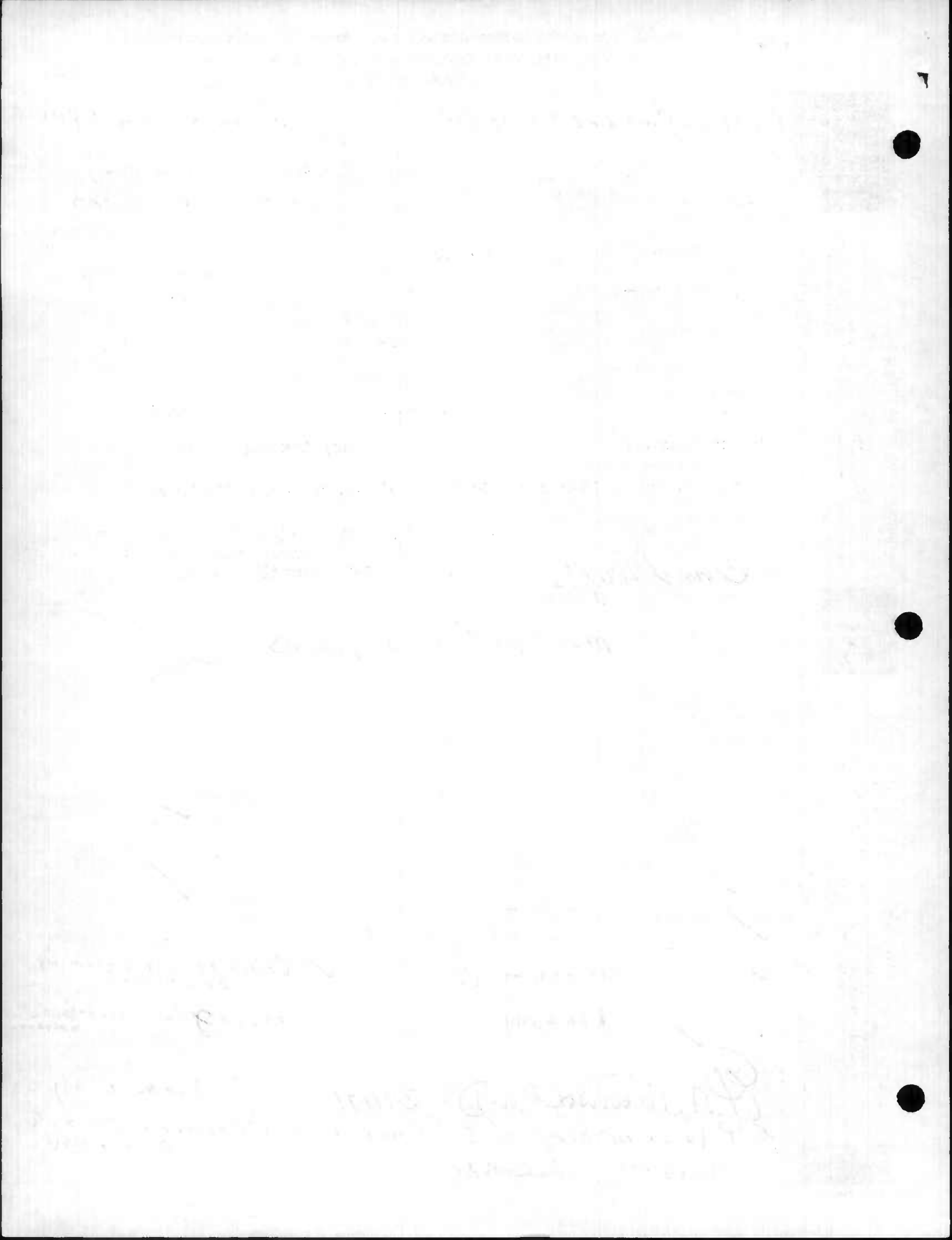
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

CHRISTOPHER SHELTON

State of Maryland / Department of Health and Mental Hygiene

Items: 23 part I, 27, 28a-f per MEO G-755 1/2/98 <sup>reb</sup> Certificate of Death

Reg. No.

97 39674

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerFuneral  
DirectorPhysician  
/Medical  
Examiner

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Christopher William Shelton</b>  |  | 2. Date of Death<br>Month <b>DEC.</b> Day <b>8,</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>0957 AM</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>3715 PASCAL AVENUE</b>   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death   |  |
| 5. Social Security Number<br><b>220-88-9786</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>34</b> Yrs.  |  |
| 8. Date of Birth (Month, Day, Year)<br><b>Nov. 28, 1963</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |   |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>   |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>3715 Pascal Ave.</b>   |  | 10f. Zip Code<br><b>21225</b>   |  |
| 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+)   |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>maintenance worker</b>  |  | 16b. Kind of Business/Industry<br><b>self-employed</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>William L. Shelton</b>  |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Pauline Elizabeth Lenhart</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>William L. Shelton/ father</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6722 Youngstown Ave. Baltimore, MD 21222</b>  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Resthaven Mem. Gardens</b>   |  | 20c. Location - City or Town, State<br><b>12/12/97 Frederick, MD</b>  |  |
| 21. Signature of Funeral Service Licensee<br><i>Catherine D. Hartzler</i>   |  | 22. Name and Address of Facility<br><b>Hartzler Funeral Home</b><br><b>11802 Liberty Rd. Libertytown, MD 21762</b>  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>ALCOHOL INTOXICATION COMPLICATING ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of): |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined   |  |
| 28a. Date of Injury (Month, Day, Year)<br><b>found 12/8/97</b>  |  | 28b. Time of Injury<br><b>4:00</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 28d. Describe how injury occurred<br><b>Unknown</b>   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Found: Residence</b>   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>3715 Pascal Ave. Baltimore, Md.</b>  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><i>Maya D. One</i>   |  | 29c. License number<br><b>O.C.M.E</b>   |  |
| 29d. Date signed (Month, Day, Year)<br><b>DEC. 9, 1997</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>W. P. Konow</b><br><b>111 Penn Street, Baltimore, Maryland 21201</b>   |  | 31. Date filed (Month, Day, Year)<br><b>DEC 11 1997</b>   |  |
| 32. Registrar's Signature<br><i>John A. Russell</i>   |  |   |  |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97-413-3368

97 39675

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John S. Sayer

2. Date of Death  
Month Day Year  
December 14, 1997

3. Time of Death  
8:30 AM

4a. Facility Name (If not institution, give street and number)

13209 Colton Lane

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

470-16-7094

6. Sex  
☒ M ☐ F

7. Age (In yrs. last birthday)  
80 Yrs.

8. Date of Birth  
(Month, Day, Year)  
July 27, 1917

9. Birthplace (State or Foreign Country)  
Minnesota

Usual Residence of Decedent

10a. State  
Maryland

10b. County  
Montgomery

10c. City, Town or Location  
Gaithersburg

10d. Inside City Limits  
☐ Yes ☒ No

10e. Street and Number

13209 Colton Lane

10f. Zip Code

20878

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.  
Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian,  
Black, White, etc.  
Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)  
Information Systems  
Consultant

16b. Kind of Business/Industry

Information Systems

17. Father's Name (First, Middle, Last)

Arthur Samuel Sayer

18. Mother's Name (First, Middle, Maiden Surname)

Genevieve Ollis

19a. Informant's Name/Relationship (Type, Print)

Elizabeth Hughes Sayer/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13209 Colton Lane, Gaithersburg, Maryland 20878

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of  
cemetery, crematory or other place)

December 16, 1997  
Montgomery Crematorium, Inc.

Date

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

M01126

22. Name and Address of Facility  
Robert A. Pumphrey Funeral Home/  
Rockville, Inc., 300 West Montgomery Avenue,  
Rockville, Maryland 20850-2805

23a. Pertinent diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and Death

Immediate Cause (Final  
disease or condition  
resulting in death)

e. Acute Cardiac Arrhythmia

Immediate

Due to (or as a consequence of):

f. Coronary Artery Heart Disease

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Carcinoma Prostate

Hypertension

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy  
performed?

☐ Yes ☒ No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

☐ Yes ☒ No

25. Was case referred to medical  
examiner?  
☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☐ Nursing Home

☒ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?  
☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier  
(Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D01948

29d. Date signed (Month, Day, Year)

December 16, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Blaine Fitzgerald, M.D., 8218 Wisconsin Ave., Bethesda, Maryland 20814

31. Date filed (Month, Day, Year)

DEC 17 1997

32. Registrar's Signature

Julia Davidson-Rendell

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39676

|   |  |  |  |  |   |  |  |  |  |  |
|---|--|--|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>PHILIP SCHAEFFER</b>  |  |  |  | 2. Date of Death<br>Month <b>DECEMBER</b> Day <b>14</b> , Year <b>1997</b>  |  |  |  | 3. Time of Death<br><b>5:30 AM</b>   |  |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>15300 BEAVERBROOK COURT #2H</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>SILVER SPRING</b>  |  |  |  | 4c. County of Death<br><b>MONTGOMERY</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>109-01-4999</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>MARCH 12, 1911</b> |  | 9. Birthplace (State or Foreign Country)<br><b>NEW YORK</b>  |  |
|   | Usual Residence of Decedent  |  |  |  | 10e. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>MONTGOMERY</b>                             |  | 10c. City, Town or Location<br><b>SILVER SPRING</b>  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 10f. Zip Code<br><b>20906</b>   |  |  |  | 10g. Citizen of What Country?<br><b>UNITED STATES</b>  |  |
|   | 10e. Street and Number<br><b>15300 BEAVERBROOK COURT #2H</b>   |  |  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  |
|   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SALESMAN</b>   |  |  |  | 16b. Kind of Business/Industry<br><b>MENSWEAR</b>   |  |  |  | 17. Father's Name (First, Middle, Last)<br><b>JACOB SCHAEFFER</b>  |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>CELIA SCHEINER</b>   |  |  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>BEVERLY KAZDEN (DAUGHTER)</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>402 IRWIN STREET - SILVER SPRING, MARYLAND 20901</b>   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>KING DAVID MEMORIAL GDNS.</b>  |  |  |  | 20c. Location - City or Town, State<br><b>12/15/97 FALLS CHURCH, VA.</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |  |  | 22. Name and Address of Facility<br><b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.</b><br><b>1170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852</b>  |  |  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>HEPATIC CELLULAR CARCINOMA</b><br>a. Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of): |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  |
|   | 28a. Date of Injury (Month, Day, Year)   |  |  |  | 28b. Time of Injury<br><b>M</b>   |  |  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 28d. Describe how injury occurred             |  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. Signature and title of certifier<br>   |  |  |  | 29c. License number<br><b>D24543</b>   |  |
|   | 29d. Date signed (Month, Day, Year)<br><b>DECEMBER 14, 1997</b>  |  |  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JAMES A. ROSSI, M.D. - 3305 N. LEISURE WORLD BLVD. - SILVER SPRING, MARYLAND 20906</b>   |  |  |  | 31. Date filed (Month, Day, Year)<br><b>DEC 16 1997</b>  |  |
|   | 32. Registrar's Signature<br>  |  |  |  | 33. State Registrar<br><b>DEC 16 1997</b>   |  |  |  | 34. DHMH 16 Rev 6/95   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Harriet Seiken

2. Date of Death

December 11, 1997

3. Time of Death

7:30am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

12609 Orchard Brook Terrace

4b. City, Town, or Location of Death

Potomac

4c. County of Death

Montgomery

5. Social Security Number

107-30-3410

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

59 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 31, 1937

9. Birthplace (State or Foreign Country)

New York, N.Y.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Potomac

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

12609 Orchard Brook Terrace

10f. Zip Code

20854

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Receptionist

16b. Kind of Business/Industry

Dentist

17. Father's Name (First, Middle, Last)

Morris Last

18. Mother's Name (First, Middle, Maiden Surname)

Sylvia Weisbach

19a. Informant's Name/Relationship (Type, Print)

Stanley Seiken/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12609 Orchard Brook Terrace Potomac, MD 20854

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Judean Mem. Gdns.

Date

12/12/97

20c. Location - City or Town, State

Olney, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ives-Pearson Funeral Home  
2847 Wilson Blvd. Arlington, VA 2220123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Metastatic Breast Cancer

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

2 years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

DC - 11506

29d. Date signed (Month, Day, Year)

12/11/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. F. Smith 5401 Western Ave. Washington, D.C. 20015

31. Date filed (Month, Day, Year)

DEC 17 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
RegistrarBaltimore, Maryland 21215-0020  
Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39678

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Paul C. Singer

2. Date of Death

Month Day Year  
December 12, 1997

3. Time of Death

11:30 PM

4a. Facility Name (If not institution, give street and number)

1600 Timberline Road

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

167-38-4604

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

49

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Oct. 2, 1948

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1600 Timberline Road

10f. Zip Code

20904

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: 1967-

1969

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Episcopal Priest

16b. Kind of Business/Industry

Religion

17. Father's Name (First, Middle, Last)

John E. Singer

18. Mother's Name (First, Middle, Maiden Surname)

Carolyn Dempsey

19a. Informant's Name/Relationship (Type, Print)

Judith L. Singer (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1600 Timberline Road Silver Spring, Maryland 20904

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Washington Memorial Chapel

Date

12/16/97

20c. Location - City or Town, State

Valley Forge, Pennsylvania

21. Signature of Funeral Service Licensee

John L. Chapak

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.  
500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Malignant Brain Tumor

Due to (or as a consequence of):

2 months

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joel L. Falik, M.D.

29c. License number

D 16518

29d. Date signed (Month, Day, Year)

December 13, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joel L. Falik, M.D. 7257B Hanover Parkway Greenbelt, Maryland 20770

31. Date filed (Month, Day, Year)

DEC 16 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39679

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY SLEZAK

2. Date of Death

Month  
12Day  
12Year  
97

3. Time of Death

4:45 p.m.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince Georges

5. Social Security Number

132-07-3255

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
November 19, 1905

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Bowie

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

12305 Manvel Lane

10f. Zip Code

20715

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

Collage (1-4or 5+)

Collage (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Factory Worker

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Emil Zurila

18. Mother's Name (First, Middle, Maiden Summa)

Mary Malenda

19a. Informant's Name/Relationship (Type, Print)

William Joseph Slezak Jr. (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12305 Manvel Lane Bowie Maryland 20715

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Most Holy Trinity Cemetery

Data

12-16-97

20c. Location - City or Town, State

Brooklyn New York

21. Signature of Funeral Service Licensee

Matthew A Brown

22. Name and Address of Facility

Borgwardt Funeral Home 4400 Powder mill Rd Beltsville Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

b. Pneumonia

Due to (or as a consequence of):

c. atrial fibrillation

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

Richard Chasen, M.D.

29c. License number

D22862

29d. Date signed (Month, Day, Year)

12/13/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RICHARD CHASEN, M.D.  
7350 VAN DUSEN RD #230 LAUREL, MARYLAND 20707

31. Date filed (Month, Day, Year)

DEC 18 1997

32. Registrar's Signature

John Davidson

State

Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39680

|   |  |   |  |   |  |   |  |  |   |  |
|---|--|---|--|---|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Garland Smith</b>                             |   |  |   |  |   | 2. Date of Death<br>Month <b>December</b> Day <b>15</b> , Year <b>1997</b> |  | 3. Time of Death<br><b>3:02 AM</b>                                |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Holy Cross Hospital</b> |   |  |   |  |   | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>               |  | 4c. County of Death<br><b>Montgomery</b>                          |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>578-07-4957</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>89</b> Yrs. |   | 8. Date of Birth (Month, Day, Year)<br><b>April 15, 1908</b>               |  | 9. Birthplace (State or Foreign Country)<br><b>North Carolina</b> |  |
|   | Usual Residence of Decedent  |   |  |   |  |   |  |  |   |  |
| 10a. State<br><b>N/A</b>  |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Washington, DC</b>  |  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |
| 10e. Street and Number<br><b>7300 14th Street, NW</b>   |  |   |  | 10f. Zip Code<br><b>20012</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>    |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Cook</b>  |  |   | 16b. Kind of Business/Industry<br><b>Food Industry</b>                     |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Unknown Smith</b>   |  |   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Emma Unknown</b>  |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Margaret S. West (daughter)</b>  |  |   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>23 Joyceton Way, Upper Marlboro, MD 20772</b> |  |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   |  | Date<br><b>12/18/97</b>   |  | 20c. Location - City or Town, State<br><b>Alexandria, VA</b>   |   |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  |   |  | 22. Name and Address of Facility<br><b>Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901</b>                |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>Ischemic heart disease</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. |  |   |  |   |  |   |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Emphysema, Asthma</b>  |  |   |  |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |
|   |  |   |  |   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
|   |  |   |  |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  |   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
|   |  |   |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   |  |
|   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  | 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br><b>041581</b>   |   |  |
|   |  |   |  | 29d. Date signed (Month, Day, Year)<br><b>12/16/97</b>  |  |   |  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>10501 Lockwood Drive Suite 250 Silver Spring, MD 20901</b>   |  |   |  |   |  |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 17 1997</b>   |  |   |  | 32. Registrar's Signature<br>  |  |   |  |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39681

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jane Herndon Smith

2. Date of Death

Month Day Year  
December 14, 1997

3. Time of Death

9:00AM

4a. Facility Name (If not institution, give street and number)

4226 Leland Street

4b. City, Town, or Location of Death

Chevy Chase

4c. County of Death

Montgomery

5. Social Security Number

214-52-3730

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
August 4, 1912

9. Birthplace (State or Foreign Country)

Idaho

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Chevy Chase

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4226 Leland Street

10f. Zip Code

20815

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Civil Service

17. Father's Name (First, Middle, Last)

Roy Herndon

18. Mother's Name (First, Middle, Maiden Surname)

Edith Scott Decker

19a. Informant's Name/Relationship (Type, Print)

Roy Herndon SteinhoffSmith/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

132 South Santa Fe Avenue, Tulsa, Oklahoma 74127-8544

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

December 16, 1997  
Montgomery Crematorium, Inc.

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

*Barbara J. McMillen Lawrence* M00831

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.  
7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrest

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Artherosclerosis

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Bilateral Carotid Artery Disease

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☒ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

29a. Certifier (Check only one)

1 ☒ Certifying Physician

2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Irene J. Tamagna M.D.*

29c. License number

D10933

29d. Date signed (Month, Day, Year)

December 16, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Irene Tamagna, M.D. 7101 Connecticut Avenue, Chevy Chase, Maryland 20815

31. Date filed (Month, Day, Year)

DEC 17 1997

32. Registrar's Signature

*John Davidson-Randall*

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39682

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Cletus

STAMPER

2. Date of Death

Month Day Year

Dec 14 97

3. Time of Death

9:40 pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

3701 International Drive #761

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

074-03-9846

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Oct. 18, 1916

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3701 International Drive #761

10f. Zip Code

20906

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1941 -

1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Dean

16b. Kind of Business/Industry

University

17. Father's Name (First, Middle, Last)

James M. Stamper

18. Mother's Name (First, Middle, Maiden Surname)

Vallie Rose Hayes

19a. Informant's Name/Relationship (Type, Print)

Rubye Stamper Hughes

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12010 Bernard Dr., Silver Spring, Md. 20902

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Park View Cemetery

Date

Dec. 20

1997

20c. Location - City or Town, State

Schenectady, N.Y.

21. Signature of Funeral Service Licensee

Thomas G. Chyburn

22. Name and Address of Facility

McGuire Funeral Service, Inc.

7400 Georgia Ave., N.W. Wash., D.C. 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Cardiac arrhythmia

Due to (or as a consequence of):

b.

Atherosclerotic heart

Due to (or as a consequence of):

c.

Disease

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

5 mins

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John S. Sauer MD

29c. License number

D08546

29d. Date signed (Month, Day, Year)

Dec 15 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Sauer 8218 W. Sconson Ave Bethesda Md.

31. Date filed (Month, Day, Year)

DEC 16 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39683

|   |   |   |  |  |  |   |   |  |
|---|---|---|--|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>NORMAN POST SALZMAN</b>  |   |  |  | 2. Date of Death<br>Month Day Year<br><b>DECEMBER 11, 1997</b>   |   | 3. Time of Death<br><b>10:30 AM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>10508 Gainsborough Road</b>  |   |  |  | 4b. City, Town, or Location of Death<br><b>Potomac</b>   |   | 4c. County of Death<br><b>Montgomery</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>132-16-3644</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                               |  | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 14, 1926</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>New York</b>   |   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Montgomery</b>   |   | 10c. City, Town or Location<br><b>Potomac</b>   |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 10e. Street and Number<br><b>10508 Gainsborough Road</b>   |  |  |   | 10f. Zip Code<br><b>20854</b>   |  |
|   | 10g. Citizen of What Country?<br><b>United States</b>   |   |  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b> |  |
|   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |   |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) <b>5+</b>                                  |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Virologist</b>  |   |  |  | 16b. Kind of Business/Industry<br><b>Scientist</b>   |   |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>David Salzman</b>   |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Pauline Post</b>   |   |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Lenore R. Salzman-Spouse</b>   |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10508 Gainsborough Rd., Potomac, MD 20854</b>                              |   |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Judean Memorial Gardens</b> |  | 20c. Date<br><b>12/14/97</b>   |   | 20d. Location - City or Town, State<br><b>Olney, MD</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br> <b>-Edward Sagel</b>  |   |  |  | 22. Name and Address of Facility<br><b>Edward Sagel Funeral Direction<br/>1091 Rockville Pike Rockville MD 20852</b>   |   |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death) <b>c. Carcinoma of the Pancreas</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Approximate Interval Between Onset and Death <b>3 months</b> |   |  |  |  |   |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |  |  |   |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |   |  |  |  |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 28d. Describe how injury occurred   |   |   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |  |  |  |   |   |  |
| 29b. Signature and title of certifier<br> <b>William H. Silverman MD</b>   |   |   |  | 29c. License number<br><b>D27985</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>Dec. 12, 1997</b>                                 |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>William H. Silverman 809 Veirs Mill RD Rockville, MD 20852</b>   |   |   |  |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 16 1997</b>   |   | 32. Registrar's Signature<br>  |  |  |  |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1. The first part of the report deals with the general situation of the country and the progress of the work during the year. It is a summary of the work done and the results obtained. It is a general statement of the work done and the results obtained.

2. The second part of the report deals with the details of the work done. It is a detailed statement of the work done and the results obtained. It is a detailed statement of the work done and the results obtained.

3. The third part of the report deals with the conclusions drawn from the work done. It is a statement of the conclusions drawn from the work done and the results obtained. It is a statement of the conclusions drawn from the work done and the results obtained.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39684

|   |   |  |   |  |  |  |   |  |
|---|---|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Bobby Ray Scott</b>                              |  |   |  | 2. Date of Death<br>Month <b>November</b> Day <b>26</b> Year <b>1997</b> |  | 3. Time of Death<br><b>7:15 P.M.</b>                          |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>9420 Stoney Ridge Road</b> |  |   |  | 4b. City, Town, or Location of Death<br><b>Springdale</b>                |  | 4c. County of Death<br><b>Prince George's</b>                 |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>423-84-1167</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>34</b> Yrs.                         |  | 8. Date of Birth (Month, Day, Year)<br><b>August 17, 1963</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Alabama</b>                                      |  | 10a. State<br><b>Alabama</b>  |  | 10b. County<br><b>Mobile</b>   |  | 10c. City, Town or Location<br><b>Mobile</b>                  |  |
| Usual Residence of Decedent   |   |  |   |  |  |  |   |  |
| 10a. State<br><b>Alabama</b>  |   |  | 10b. County<br><b>Mobile</b>  |  |  | 10c. City, Town or Location<br><b>Mobile</b>   |   |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |  | 10e. Street and Number<br><b>1510 Flowers Drive</b>   |  |  | 10f. Zip Code<br><b>36605</b>  |   |  |
| 10g. Citizen of What Country?<br><b>United States of America</b>  |   |  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |   |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>College (1-4or 5+)</b>  |   |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>STORE MANAGER</b>   |   |  | 16b. Kind of Business/Industry<br><b>DRUG STORE</b>   |  |  | 17. Father's Name (First, Middle, Last)<br><b>Mazell Scott, Sr.</b>  |   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Willie Kate Smith</b>   |   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Willie Kate Smith Scott/ Mother</b>  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1510 FLOWERS DR, Mobile AL 36605</b>   |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Pinecrest Cemetery</b>   |  |  | 20c. Location - City or Town, State<br><b>12/6/97 Mobile, Alabama</b>  |   |  |
| 21. Signature of Funeral Service Licensee #M00690<br>   |   |  | 22. Name and Address of Facility<br><b>Hodges Funeral Home 36603 701 Martin Luther King Avenue, Mobile, Alabama</b>   |  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>Pulmonary Kaposi's Sarcoma</b><br>Due to (or as a consequence of):<br><b>Acquired Immune Deficiency Syndrome</b><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Mycobacterium Avium Infection</b>  |   |  |   |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |  |  |  |   |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide               |   |  | 28a. Date of Injury (Month, Day Year)   |  |  | 28b. Time of Injury<br><b>M</b>  |   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  | 28d. Describe how injury occurred   |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  | 29b. Signature and title of certifier<br>   |   |  |
| 29c. License number<br><b>D0052381</b>  |   |  | 29d. Date signed (Month, Day, Year)<br><b>November 27, 1997</b>   |  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Robyn D. Anderson, Holy Cross Hospital, 1500 Forest Glen Road</b>   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 08 1997</b>   |   |  | 32. Registrar's Signature<br>  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



AM

WALTER  
SMITH

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

07 39685

|  |  |  |  |  |  |   |  |  |
|--|--|--|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Walter Etheredge Smith</b>                          |  |  |  | 2. Date of Death<br>Month Day Year<br><b>DECEMBER 03, 1997</b> |   | 3. Time of Death<br><b>1:50 P</b>                          |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>NORTH ARUNDEL HOSPITAL ER</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>Glen Burnie</b>     |   | 4c. County of Death<br><b>ANNE ARUNDEL</b>                 |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>216-24-8770</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs.               |   | 8. Date of Birth (Month, Day, Year)<br><b>Feb 29, 1928</b> |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Anne Arundel</b>                             |   | 10c. City, Town or Location<br><b>Glen Burnie</b>          |  |
| Usual Residence of Decedent  |  |  |  |  |  |   |  |  |
| 10a. State<br><b>MD</b>  |  |  | 10b. County<br><b>Anne Arundel</b>   |  |  | 10c. City, Town or Location<br><b>Glen Burnie</b>   |  |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  | 10e. Street and Number<br><b>311C Mountain Ridge Court</b>   |  |  | 10f. Zip Code<br><b>21061</b>   |  |  |
| 10g. Citizen of What Country?<br><b>USA</b>  |  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced |  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+)                       |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Engineer</b>   |  |  | 16b. Kind of Business/Industry<br><b>Aerospace Engineering</b>   |  |  | 17. Father's Name (First, Middle, Last)<br><b>Walter B. Smith</b>   |  |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elma Gladys Taylor</b>   |  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Doris Bamberger</b>   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>152 Dunshippin Lane, Newport, NC 28570</b>    |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>   |  |  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>   |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |  | 22. Name and Address of Facility<br><b>Barranco &amp; Sons, P.A. Severna Park Funeral Home<br/>495 Gov. Ritchie Hwy., Severna Park, MD 21146</b>                               |  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. Multiple Injuries</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d.</b> |  |  |  |  |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |  |  |  |   |  |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |  |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |  |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |  |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |  |  |  |   |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined  |  |  |  |  |  |   |  |  |
| 28a. Date of Injury (Month, Day, Year)<br><b>12-3-97</b>   |  |  |  |  |  |   |  |  |
| 28b. Time of Injury<br><b>1318 M</b>   |  |  |  |  |  |   |  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |  |  |   |  |  |
| 28d. Describe how injury occurred<br><b>Struck by car</b>  |  |  |  |  |  |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Street</b>  |  |  |  |  |  |   |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Anne Arundel County, Maryland</b>   |  |  |  |  |  |   |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |  |  |  |   |  |  |
| 29b. Signature and title of certifier<br><br><b>OCME</b>   |  |  |  |  |  |   |  |  |
| 29c. License number<br><b>DECEMBER 04, 1997</b>  |  |  |  |  |  |   |  |  |
| 29d. Date signed (Month, Day, Year)  |  |  |  |  |  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201</b>   |  |  |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 11 1997</b>  |  |  |  |  |  |   |  |  |
| 32. Registrar's Signature<br>  |  |  |  |  |  |   |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-386-0000.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



97 39686

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |   |                                   |  |   |   |   |
|--|--|--|---|---|-----------------------------------|--|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Carrie Smith</i>  |  |  |   | 2. DATE OF DEATH<br>MONTH <i>DECEMBER</i> DAY <i>14</i> YEAR <i>1997</i>  |                                   |  |   | 3. TIME OF DEATH<br><i>1:25 P.M.</i>                        |   |
| 4. SOCIAL SECURITY NUMBER<br><i>219-07-2953</i>  |  | 5. SEX<br><i>1</i> <input type="checkbox"/> M <i>2</i> <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><i>93</i> YRS.  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS   | IF UNDER 24 HRS.<br>HOURS<br>MIN. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>Nov. 20, 1904</i>                                     |   | 8. BIRTHPLACE (State or Foreign Country)<br><i>Maryland</i> |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Caton Manor Genesis Elder Care</i>  |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Baltimore</i>   |                                   |  | 9c. COUNTY OF DEATH<br><i>Baltimore</i>   |   |   |
| RESIDENCE OF DECEDENT  |  |  |   |   |                                   |  |   |   |   |
| 10a. STATE<br><i>Maryland</i>  |  | 10b. COUNTY<br><i>Baltimore</i>  |   | 10c. CITY, TOWN OR LOCATION<br><i>Baltimore</i>   |                                   |  | 10d. INSIDE CITY LIMITS?<br><i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO |   |   |
| 10e. STREET AND NUMBER<br><i>3234 Magnolia Avenue</i>  |  |  |   | 10f. ZIP CODE<br><i>21227</i>   |                                   | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |   |   |   |
| 11. MARITAL STATUS<br><i>3</i> <input checked="" type="checkbox"/> Widowed <i>4</i> <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO Specify: |                                   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>white</i>   |   |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>6</i> College (1-4 or 8+) <i>0</i>  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>homemaker</i> |   |                                   | 16b. KIND OF BUSINESS/INDUSTRY<br><i>her own home</i>  |   |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>George Washington Row</i>  |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Lilly Mae Munday</i>  |                                   |  |   |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Norma B. Smith</i>  |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>3234 Magnolia Avenue, Baltimore, Md. 21227</i>  |                                   |  |   |   |   |
| 20a. METHOD OF DISPOSITION<br><i>1</i> <input checked="" type="checkbox"/> Burial <i>2</i> <input type="checkbox"/> Cremation <i>3</i> <input type="checkbox"/> Removal from State<br><i>4</i> <input type="checkbox"/> Donation <i>5</i> <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Rose Hill Cemetery</i>   |   | DATE<br><i>12-17-97</i>   |                                   | 20c. LOCATION — City or Town, State<br><i>Hagerstown, Md.</i>                                      |   |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Scott Miner</i>  |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br><i>MINNICK FUNERAL HOME</i><br><i>415 E. Wilson Blvd., Hagerstown, Md. 21740</i>  |                                   |  |   |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Acute Myocardial Infarction</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |   |   |                                   |  |   |   | Approximate Interval Between Onset and Death<br><i>few hours</i>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Hypertension</i><br><i>Breast cancer</i>  |  |  |   |   |                                   |  |   |   | 24a. WAS AN AUTOPSY PERFORMED?<br><i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO   |  |  |   |   |                                   |  |   |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <i>1</i> <input type="checkbox"/> Inpatient <i>2</i> <input type="checkbox"/> ER/Outpatient <i>3</i> <input type="checkbox"/> DOA<br>OTHER: <i>4</i> <input checked="" type="checkbox"/> Nursing Home <i>5</i> <input type="checkbox"/> Residence <i>6</i> <input type="checkbox"/> Other (Specify) |   |   |                                   |  |   |   |   |
| 27. MANNER OF DEATH<br><i>1</i> <input checked="" type="checkbox"/> Natural <i>5</i> <input type="checkbox"/> Pending Investigation<br><i>2</i> <input type="checkbox"/> Accident <i>3</i> <input type="checkbox"/> Suicide <i>4</i> <input type="checkbox"/> Homicide<br><i>a</i> <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |   | 28b. TIME OF INJURY<br>M  |                                   | 28c. INJURY AT WORK?<br><i>1</i> <input type="checkbox"/> YES <i>2</i> <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED                           |   |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |   |   |                                   |  |   |   |   |
| 29a. CERTIFIER (Check only one)<br><i>1</i> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><i>2</i> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |   |   |                                   |  |   |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Dr. Ochaney MD</i>   |  |  |   | 29c. LICENSE NUMBER<br><i>D-40521</i>   |                                   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>December 15, 1997</i>   |   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>DR. OCHANAY 3350 WILKENS AVENUE SUITE 302 BALTIMORE, MD 21229</i>  |  |  |   |   |                                   |  |   |   |   |
| 31. DATE FILED (Month, Day, Year)<br><i>DEC 17 1997</i>  |  |  |   | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |                                   |  |   |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68780

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

EXPLANATION

THE ABOVE

THE ABOVE

EXPLANATION

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39687

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLES GARRISON SCROGGINS, JR

2. Date of Death

Month

Day

Year

12

14

97

3. Time of Death

11:45pm

4a. Facility Name (If not institution, give street and number)

11901 Comanche Drive

4b. City, Town, or Location of Death

Smithsburg

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

226-36-3874

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 12, 1932

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Smithsburg

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

11901 Comanche Drive

10f. Zip Code

21783

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: 1951-

1955

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Trucking Company

17. Father's Name (First, Middle, Last)

Charles Garrison Scroggins, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Lillie Mae Settle

19a. Informant's Name/Relationship (Type, Print)

Peggy Ann Olmstead, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

R.R. Box 213 M, Hedgesville, West Virginia 25427

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Rocky Gap Veterans Cemetery

Date

Dec. 17

20c. Location - City or Town, State

Cumberland, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Douglas A. Fiery Funeral Home

1331 Eastern Blvd. N., Hagerstown, Maryland 21742

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last:

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

YEARS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION, DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D38892

29d. Date signed (Month, Day, Year)

12/16/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAMELA FOX BRADFORD MD 1110 MEDICAL CAMPUS RD. HAGERSTOWN, MD 21742

31. Date filed (Month, Day, Year)

DEC 16 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 97 39688

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

THOMAS HARWOOD SNYDER

2. Date of Death

DEC

Day

Year

3. Time of Death

12:31 AM

4a. Facility Name (If not institution, give street and number)

112 Sunflower Dr.

4b. City, Town, or Location of Death

Hagerstown,

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

219-07-9212

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Dec. 17, 1916

9. Birthplace (State or Foreign Country)

WV

Usual Residence of Decedent

10e. State

MD

10b. County

Washington

10c. City, Town or Location

Hagerstown,

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

112 Sunflower Dr.

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12 yearsCollege (14 or 5+)  
016a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

production superintendent Brick Factory

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Thomas Jefferson Snyder

18. Mother's Name (First, Middle, Maiden Surname)

Mary Virginia Kitchen

19a. Informant's Name/Relationship (Type, Print)

Glennie Snyder

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

112 Sunflower Dr. Hagerstown, MD 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Shanktown Cem. Dec. 17, 1997

Date

20c. Location - City or Town, State

Big Pool, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Thompson Funeral Home, Inc.

P.O. Box 310 Clear Spring, MD. 21722

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

e. Cardiac pulmonary Arrest

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Respiratory Failure

Due to (or as a consequence of):

c. Chronic pulmonary Fibrosis

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

29 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Francisco L. Andrade

29c. License number

D27898

29d. Date signed (Month, Day, Year)

Dec. 16, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCISCO L. ANDRADE 350 MILL ST. HAGERSTOWN MD 21740

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 18 1997

32. Registrar's Signature

Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39689

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Albert Lee Scott JR

2. Date of Death

12 Mo 97

3. Time of Death

20:30

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

219-12-2001

6. Sex

M 20 F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 2, 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

Yes 2 No

10a. Street and Number

420 Belview Avenue

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

1 Yes 2 No  
If Yes, Give  
Year or Dates: W.W. II13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
416a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Cost Analyst

16b. Kind of Business/Industry

Aircraft Industry

17. Father's Name (First, Middle, Last)

Albert Lee Scott, Sr.

18. Mother's Name (First, Middle, Maiden Summa)

Helen Lashley

19a. Informant's Name/Relationship (Type, Print)

Marie S. Scott

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

420 Belview Avenue Hagerstown, Md. 21740

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Hagerstown Crematory

Date

12-19-97

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

Scott Minnich

22. Name and Address of Facility

Minnich Funeral Home

415 E. Wilson Blvd. Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Coronary heart disease

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Coronary artery disease

Due to (or as a consequence of):

years

c. Atherosclerosis

Due to (or as a consequence of):

years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive cardiomyopathy

Renal Insufficiency

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy  
performed?

1 Yes 2 No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 Yes 2 No

25. Was case referred to medical  
examiner?

1 Yes 2 No

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending  
2 Accident 6 investigation  
3 Suicide 6 Could not be  
4 Homicide 6 determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?

1 Yes 2 No

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner as stated.

29b. Signature and title of certifier

W. S. Hood MD

29c. License number

D 21400

29d. Date signed (Month, Day, Year)

12-16-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

249 Mill St., Hagerstown, Md. 21740

31. Date filed (Month, Day, Year)

DEC 19 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

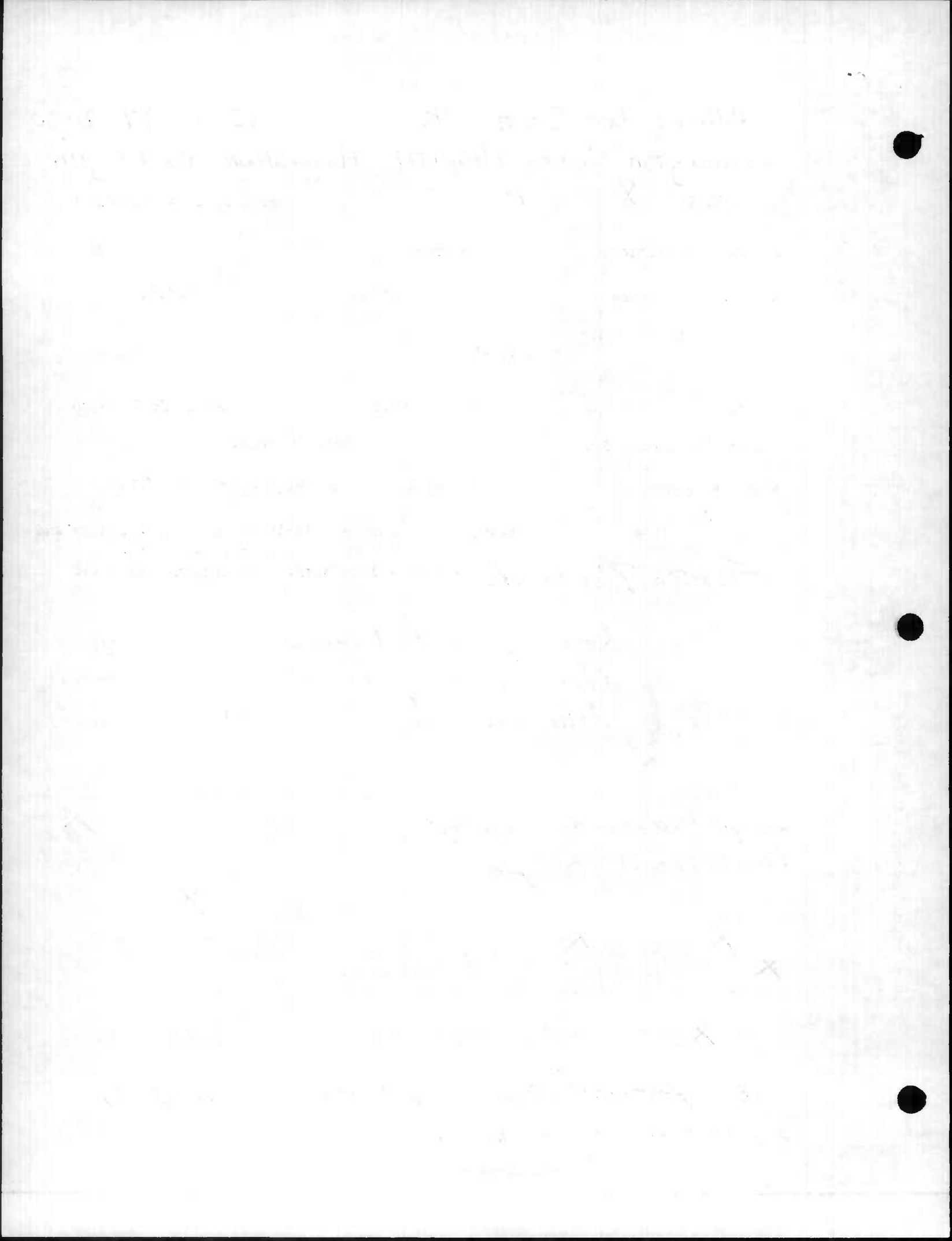
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39690

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jeanette Spriggs

2. Date of Death

Month Day Year  
December 10 1997

3. Time of Death

12:15 PM

4a. Facility Name (If not institution, give street and number)

Heartland Healthcare Center

4b. City, Town, or Location of Death

Hyattsville

4c. County of Death

Prince George's

5. Social Security Number

577-32-5866

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug 23 1926

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

District

10b. County

of Columbia

10c. City, Town or Location

Washington

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2700 Jasper St., S.E. #317

10f. Zip Code

20020

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: African American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Food Service

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Bishop King Phillips, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mary Ann Welch

19a. Informant's Name/Relationship (Type, Print)

Diane M. Shelton/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1517 Queen St., N.E. Wash., D.C. 20002

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Park

Date

12/17/97

20c. Location - City or Town, State

Landover, MD

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

Stewart Funeral Home  
4001 Benning Rd., N.E. Wash., D.C. 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Coronary Arteries

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that preceded events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Sepsis, Stage IV Sepsis  
peripheral vascular disease, Dementia,  
Non Insulin Dependent Diabetes

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined☐ Could not be determined☐ Could not be determined

28a. Date of Injury (Month, Day Year)

N/A

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Paul A. DeVore MD

29c. License number

D01852

29d. Date signed (Month, Day, Year)

DECEMBER 11, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

PAUL A. DEVORE MD 4203 Queensbury Rd Hyattsville (and

31. Date filed (Month, Day, Year)

DEC 15 1997

32. Registrar's Signature

John T. Stewart III

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39691

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Rita Mae Smith

2. Date of Death

Month Day Year  
December 12, 1997

3. Time of Death

9:20 a.m.

4a. Facility Name (If not institution, give street and number)

20036 Nicodemus Mill Road

4b. City, Town, or Location of Death

Keedysville

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

220-12-3183

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 2, 1913

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland Prince George's

10b. County

10c. City, Town or Location

College Park

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9707 53rd Avenue

10f. Zip Code

20740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Quality Control Agent

16b. Kind of Business/Industry

Stone Industry

17. Father's Name (First, Middle, Last)

Eugene Aleshire

18. Mother's Name (First, Middle, Maiden Surname)

Lula Southard

19a. Informant's Name/Relationship (Type, Print)

Janet R. Hanna - Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20036 Nicodemus Mill Road, Keedysville, MD 21756

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland National Memorial Park

Date

12/16/97

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

Henry L. Lark

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home P.A.  
4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Carcinoma of Cervix  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Abdul Waheed

29c. License number

021457

29d. Date signed (Month, Day, Year)

12-16-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ABDUL WAHEED MD - 12821 OAK HILL AVE. HAGERSTOWN MD 21742

31. Date filed (Month, Day, Year)

DEC 17 1997

32. Registrar's Signature

John Anderson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

(5)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 39692

|  |   |   |   |   |  |  |   |   |
|--|---|---|---|---|--|--|---|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Carey Speller</b>  |   |   |   | 2. Date of Death<br>Month <b>December</b> Day <b>14</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>8:05 A.M.</b>                                    |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Stella Maris Hospice</b>   |   |   |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>N/A</b>                                       |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>224-40-4313</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (in yrs. last birthday)<br><b>61</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>Nov. 2, 1936</b>           | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b> |
|  | Usual Residence of Decedent   |   |   |   | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Prince George's</b>                                   |   |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 10e. Street and Number<br><b>11301 Kettering Way</b>  |   | 10f. Zip Code<br><b>20772</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                             |   |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>Retired</b><br>If Yes, Give Year or Dates: <b>08/79</b> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |   |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)<br><b>4</b>  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Computer Systems Analyst</b>                               |   | 16b. Kind of Business/Industry<br><b>Consulting</b>  |  |   |   |
|  | 17. Father's Name (First, Middle, Last)<br><b>Charlie Speller</b>   |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Alberta Walker</b>   |  |   |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Carey Speller II/Son</b>   |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>210 Fair Oaks Ave., Stafford, Va. 22554</b>  |  |   |   |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Maryland Veterans Cem. 12/19/1997</b>  |   | 20c. Location - City or Town, State<br><b>Cheltenham, MD</b>   |  |   |   |
|  | 21. Signature of Funeral Service Licensee<br><b>George P. Kalas</b>   |   | 22. Name and Address of Facility<br><b>George P. Kalas Funeral Home<br/>6160 Oxon Hill Rd., Oxon Hill, MD 20745</b>   |   |  |  |   |   |
|  | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Malignant Neoplasm of Pancreas, NOS</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. <b>2 months</b> |   |   |   |  |  |   |   |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |   |   |   |  |  |   |   |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b> |  |  |   |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)                                  |   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   | 28d. Describe how injury occurred                           |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><b>Thomas M. Annulis, M.D.</b> |   | 29c. License number<br><b>D0052401</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>December 14, 1997</b>                  |   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Thomas M. Annulis, M.D.; 2801 Hudson Street; Baltimore, MD 21224</b>  |   |   |   |   |  |  |   |   |
| 31. Date filed (Month, Day, Year)<br><b>DEC 17 1997</b>  |   |   |   | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |   |   |

Baltimore, Maryland 21215-0020

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,  
Baltimore, Maryland 21215-0020

State  
Registrar

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 39693**  
**Certificate of Death**

Reg. No.

Physician  
/Medical  
Examiner

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Debra Sobers</b>                                     |  |  |  | 2. Date of Death<br>Month <b>12</b> Day <b>16</b> Year <b>97</b> |  | 3. Time of Death<br><b>8:45 PM</b>                     |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>11042 Spy Glass Hill Court</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>Mitchellville</b>     |  | 4c. County of Death<br><b>Prince George's</b>          |  |
| 5. Social Security Number<br><b>463-98-0953</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>45</b> Yrs.                 |  | 8. Date of Birth (Month, Day, Year)<br><b>11-21-52</b> |  |
| 9. Birthplace (State or Foreign Country)<br><b>Indiana</b>  |  |  |  |  |  |  |  |

Funeral  
Director

|   |                                       |   |  |
|---|---------------------------------------|---|--|
| Usual Residence of Decedent   |                                       |   |  |
| 10a. State<br><b>Maryland</b>                                       | 10b. County<br><b>Prince George's</b> | 10c. City, Town or Location<br><b>Mitchellville</b> |  |
| 10d. Inside City Limits<br><b>Yes</b> 2 <input type="checkbox"/> No |                                       |   |  |

|   |  |                               |  |   |  |
|---|--|-------------------------------|--|---|--|
| 10e. Street and Number<br><b>11042 Spy Glass Hill Court</b> |  | 10f. Zip Code<br><b>20721</b> |  | 10g. Citizen of What Country?<br><b>USA</b> |  |
|---|--|-------------------------------|--|---|--|

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |
|--|--|---|--|--|--|---|--|

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+</b> |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Contract Writer</b> |  | 16b. Kind of Business/Industry<br><b>Government</b> |  |
|--|--|---|--|---|--|

|   |  |   |  |
|---|--|---|--|
| 17. Father's Name (First, Middle, Last)<br><b>Willie M. Dixon</b> |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Olivia Harrison</b> |  |
|---|--|---|--|

|  |  |   |  |
|--|--|---|--|
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Arthur Sobers/Husband</b> |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11042 Spy Glass Hill Court, Mitchellville, MD 20721</b> |  |
|--|--|---|--|

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Ft. Sam Houston Natl Cem</b> |  | 20c. Location - City or Town, State<br><b>San Antonio, Texas</b> |  |
|---|--|---|--|--|--|

|  |  |  |  |
|--|--|--|--|
| 21. Signature of Funeral Service Licensee<br><b>Charles J. Bowms</b> |  | 22. Name and Address of Facility<br><b>J. B. Jenkins Funeral Home<br/>7474 Landover Road, Landover, Maryland 20785</b> |  |
|--|--|--|--|

|  |  |  |  |
|--|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Non Small Carcinoma of the Lung</b><br>Due to (or as a consequence of):<br><br><b>b.</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b> |  | Approximate Interval Between Onset and Death |  |
|--|--|--|--|

|  |  |  |  |
|--|--|--|--|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
|  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 28. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  |
|   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |

|  |  |
|--|--|
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> <b>Certifying Physician</b> : To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> <b>Medical Examiner</b> : On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |
|--|--|

|   |  |                                       |  |   |  |
|---|--|---------------------------------------|--|---|--|
| 29b. Signature and title of certifier<br><b>Alfred B. Brooks MD</b> |  | 29c. License number<br><b>C024898</b> |  | 29d. Date signed (Month, Day, Year)<br><b>December 17, 1997</b> |  |
|---|--|---------------------------------------|--|---|--|

|   |  |
|---|--|
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Alfred B. Brooks, M.D., 6900 Georgia Avenue N.W. Washington DC 20307</b> |  |
|---|--|

|   |  |   |  |
|---|--|---|--|
| 31. Date filed (Month, Day, Year)<br><b>DEC 18 1997</b> |  | 32. Registrar's Signature<br><b>J. B. Jenkins</b> |  |
|---|--|---|--|

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

20

State  
Registrar

End of the world  
1988 81330

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39694

|   |  |  |  |   |   |  |   |   |  |
|---|--|--|--|---|---|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>JAMES CLAUDE SMITH</b>  |  |  |   | 2. Date of Death<br>Month <b>DECEMBER</b> Day <b>8</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>12:54 AM</b>   |   |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>SNAI HOSPITAL</b>   |  |  |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death<br><b>----</b>  |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-18-0518</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 10, 1921</b>  |   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Harford</b>   |  | 10c. City, Town or Location<br><b>Churchville</b>   |   |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   | 10e. Street and Number<br><b>3003 Rolling Green Drive</b>   |  | 10f. Zip Code<br><b>21028</b>   |   |  |
|   | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                              |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   |  |
|   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+)                      |   |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Farmer</b>   |  |  |   | 16b. Kind of Business/Industry<br><b>Agriculture</b>  |  |   |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>H. Edgar Smith</b>   |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helen Honora Treadwell</b>  |  |   |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Frances T. Smith - Wife</b>   |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3003 Rolling Green Dr., Churchville, MD 21028</b>   |  |   |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Harford Memorial Gardens</b>   |  | 20c. Location - City or Town, State<br><b>Churchville, Maryland</b>   |   |  |
|   | 21. Signature of Funeral Service/Licensee<br>  |  |  |   | 22. Name and Address of Facility<br><b>Howard K. McComas III Funeral Home, P.A.<br/>1317 Cokesbury Road, Abingdon, Maryland 21009</b>   |  |   |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>CORONARY ARTERY DISEASE</b><br>Due to (or as a consequence of):<br><br>b. <b>PULMONARY EDEMA</b><br>Due to (or as a consequence of):<br><br>c. <b>PARAPLEGIA</b><br>Due to (or as a consequence of):<br><br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |   | Approximate Interval Between Onset and Death  |  |   |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |   |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  |  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 28d. Describe how injury occurred   |  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |  | 29b. Signature and title of certifier<br>   |   | 29c. License number<br><b>H50128</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>DECEMBER 9, 1997</b>                              |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ALAN MORRISON, MD 2401 WEST BELVEDERE AVENUE BALTIMORE, MARYLAND 21215</b>   |  |  |  | 31. Date filed (Month, Day, Year)<br><b>DEC 10 1997</b>   |   |  |   | 32. Registrar's Signature<br>   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39695

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES LESTER SPICER

2. Date of Death  
Month Day Year

DECEMBER 01, 1997

3. Time of Death

20:34

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

Funeral  
Director

5. Social Security Number

212-16-2670

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 20, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

104 Dublin Court

10f. Zip Code

21014

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No WW II  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Fireman

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

James Elmer Spicer

18. Mother's Name (First, Middle, Maiden Surname)

Ella (UK) Ray

19a. Informant's Name/Relationship (Type, Print)

Helen H. Spicer/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

104 Dublin Court, Bel Air, MD 21014

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bel Air Memorial Gardens

Date

12/5/97

20c. Location - City or Town, State

Bel Air, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Howard K. McComas III Funeral Home, P.A.  
50 W. Broadway St., Bel Air, MD 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause for each line.

Immediate Cause (Final disease or condition resulting in death)

e.

SEPSIS

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 WEEKS

b.

NECROTIZING PANCREATITIS

Due to (or as a consequence of):

7 WEEKS

c.

ACUTE RENAL FAILURE

Due to (or as a consequence of):

7 WEEKS

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

28. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

DECEMBER 1, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

SONIA MOKGETHI

401 WEST REDWOOD STREET

BALTIMORE, MARYLAND 21201

31. Date filed (Month, Day, Year)

DEC 4 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

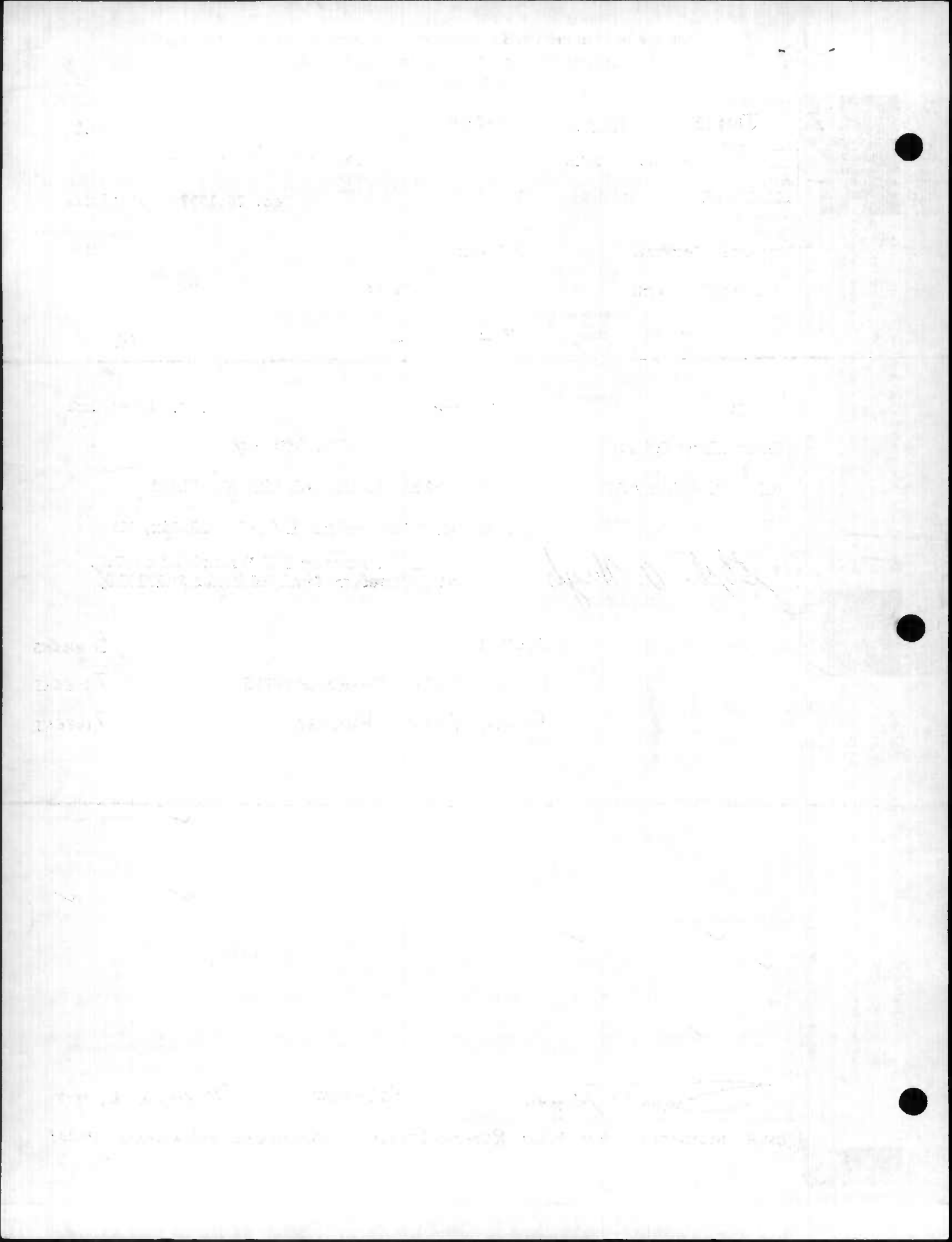
Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39696

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLOTTE LOUISE SHERTINGER

2. Date of Death

Month  
Dec.Day  
17Year  
1997

3. Time of Death

4:10 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Harford Memorial Hospital

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

5. Social Security Number

283-18-7585

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 10, 1921

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10e. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

906 Brighton Court

10f. Zip Code

21014

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Maxwell Robert Herzberg

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Elizabeth Gump

19a. Informant's Name/Relationship (Type, Print)

Laura K. Smith/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

906 Brighton Court, Bel Air, MD 21014

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Hilltop Service Corp.

Date

12/18/97

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Howard K. McComas III Funeral Home, P.A.  
1317 Cokesbury Road, Abingdon, MD 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a. Leukostasis Syndrome

Due to (or as a consequence of):

b. Acute Myelocytic Leukemia

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

days

One year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury28c. Injury at  
Work?M 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D14036

29d. Date signed (Month, Day, Year)

December 18, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R. de los SANTOS MD PA 2835 CHURCHVILLE, MARYLAND 21028

31. Date filed (Month, Day, Year)

DEC 19 1997

32. Registrar's Signature

State  
Registrar

12-17-97 12 1610 FAX 410-939-4520

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

SHERTINGER, Charlotte



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item#11 per Inf G 758 4/21/98 EW

## Certificate of Death

Reg. No.

97 39697

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Patricia Anne Schaeffer

2. Date of Death

Month

Day

Year

Dec.

8

1997

3. Time of Death

2:00PM

4a. Facility Name (If not institution, give street and number)

1401 Haven Road Apt #B 12

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

212-38-8975

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

57

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

08/04/1940

9. Birthplace (State or Foreign Country)

W.V.

Usual Residence of Decedent

10a. State

MD.

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1401 Haven Road Apt # B12

10f. Zip Code

21742-3071

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married2 ☒ Married3 ☐ Widowed4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes2 ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

clerical

16b. Kind of Business/Industry

Census Bureau

17. Father's Name (First, Middle, Last)

Franklin S. Phillips

18. Mother's Name (First, Middle, Maiden Surname)

Opal Montgomery

19a. Informant's Name/Relationship (Type, Print)

George Hammersla

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

146 Woodbury Avenue Martinsburg, WV 25401

20a. Method of Disposition

1 ☒ Burial2 ☐ Cremation3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rosedale Cemetery

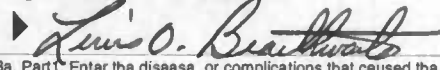
Date

12/12/97

20c. Location - City or Town, State

Martinsburg, WV 25401

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Rosedale Funeral Chapel, Inc  
2060 Rosedale Rd., Mtsbg, WV 25401

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

30 mins.

Due to (or as a consequence of):

b. ADULT ONSET DIABETES

10 yrs.

Due to (or as a consequence of):

c. OPEN DIABETIC WOUND - INFECTED

8 mos.

Due to (or as a consequence of):

d. HYPERTENSIVE HEART DISEASE

10 yrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOAOther: 4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

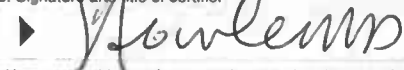
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D50738

29d. Date signed (Month, Day, Year)

12/10/97

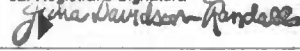
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SANDRA FOWLER MD 23A N. POTOMAC ST. HAGERSTOWN, MD 21740

31. Date filed (Month, Day, Year)

DEC 12 1997

32. Registrar's Signature


State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39698

|   |   |  |   |  |  |                                |  |   |
|---|---|--|---|--|--|--------------------------------|--|---|
| Physician<br>/Medical<br>Examiner                       | 1. Decedent's Name (First, Middle, Last)<br><b>ROGER LEE SHOOP SR.</b>  |  |   |  | 2. Date of Death<br>Month <b>December</b> Day <b>11</b> Year <b>1997</b>   |                                | 3. Time of Death<br><b>1105</b>  |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>WASHINGTON COUNTY HOSPITAL</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>HAGERSTOWN</b>  |                                | 4c. County of Death<br><b>WASHINGTON</b>   |   |
| Funeral<br>Director                                     | 5. Social Security Number<br><b>220-58-3796</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>46</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>SEPT. 4, 1951</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |
|   | Usual Residence of Decedent   |  |   |  |  |                                |  |   |
| To Be Completed by Funeral Director                     | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>WASHINGTON</b>  |  | 10c. City, Town or Location<br><b>BOONSBORO</b>  |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
|   | 10e. Street and Number<br><b>21318 MT. LENA ROAD</b>  |  |   |  | 10f. Zip Code<br><b>21713</b>  |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                        |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>TRUCK DRIVER</b>                  |  | 16b. Kind of Business/Industry<br><b>FUEL DELIVERY COMPANY</b>   |                                |  |   |
| To Be Completed by Physician/Medical Examiner           | 17. Father's Name (First, Middle, Last)<br><b>THURMAN A. SHOOP SR.</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>CARRIE V. MILEY</b>  |                                |  |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>ROSE M. SHOOP/SPOUSE</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>21318 MT. LENA ROAD, BOONSBORO, MARYLAND 21713</b>                                       |                                |  |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>BOONSBORO CEMETERY</b>   |  | 20c. Date<br><b>12/15/97</b>   |                                | 20d. Location - City or Town, State<br><b>BOONSBORO, MARYLAND</b>                              |   |
|   | 21. Signature of Funeral Service Licensee<br> <b>Paul M. Dean</b>   |  | 22. Name and Address of Facility<br><b>BAST FUNERAL HOME</b><br><b>7606 Old National Pike</b><br><b>Boonsboro, Maryland 21713</b>                 |  |  |                                |  |   |
| Physician<br>/Medical<br>Examiner                       | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>APPARENT MYOCARDIAL INFARCTION</b><br>Due to (or as a consequence of):<br><br>b. <b>ATHEROSCLEROTIC HEART DISEASE</b><br>Due to (or as a consequence of):<br><br>c. <b>PREVIOUS MYOCARDIAL INFARCTION</b><br>Due to (or as a consequence of):<br><br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |                                |  | Approximate Interval Between Onset and Death<br><br><b>MIN</b><br><br><b>yes</b><br><br><b>yes</b>  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |                                |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |                                |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |                                |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
| State Registrar   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |   |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28d. Describe how injury occurred  |                                |  |   |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |                                |  |   |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |                                |  |   |
| State Registrar   | 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br><b>D 12194</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>Dec 12 1997</b>                                      |   |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>LEONARD STOUTCH JR MD 348 MILLER HAGERSTOWN MD 20640</b>   |  |   |  |  |                                |  |   |
| 31. Date filed (Month, Day, Year)<br><b>DEC 12 1997</b> |   | 32. Registrar's Signature<br> |   |  |  |                                |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Roger Lee Shoop

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39699

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Karen Sanders Sherman

2. Date of Death

Dec. 13, 1997

3. Time of Death

1:20 A.M.

4a. Facility Name (If not institution, give street and number)

13782 Blythedale Dr.

4b. City, Town, or Location of Death

Mt. Airy

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

313-50-3027

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

49 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 23, 1948

9. Birthplace (State or Foreign Country)

Indiana

Usual Residence of Decedent

10a. State

Md.

10b. County

Frederick

10c. City, Town or Location

Mt. Airy

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13782 Blythedale Dr.

10f. Zip Code

21771

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

To Be Completed by Funeral Director

To Be Completed by Funeral Director

To Be Completed by Funeral Director

To Be Completed by Funeral Director

To Be Completed by Funeral Director

To Be Completed by Funeral Director

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Director

16b. Kind of Business/Industry

Y.M.C.A.

17. Father's Name (First, Middle, Last)

Cleophas O. Sanders

18. Mother's Name (First, Middle, Maiden Surname)

Dolores A. Blankenship

19a. Informant's Name/Relationship (Type, Print)

David L. Sherman (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13782 Blythedale Dr. Mt. Airy Md. 21771

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Smithsburg Crematory Dec. 14, 1997

Date

20c. Location - City or Town, State

Smithsburg, Md.

21. Signature of Funeral Service Licensee

Kenneth A. Davis

22. Name and Address of Facility

Davis Funeral Home

12525 Bradbury Ave. Smithsburg, Md. 21783

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. GLIOBLASTOMA MULTIFORME

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 1/3 YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sharon Sherman MD

29c. License number

023683

29d. Date signed (Month, Day, Year)

12/17/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STEVEN A. GROSSMAN MD

THE JOHNS HOPKINS ONCOLOGY CENTER

600 N. WOLFE ST. BALTIMORE 21287

31. Date filed (Month, Day, Year)

DEC 22 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

To Be Completed by Physician/Medical Examiner

To Be Completed by Physician/Medical Examiner

To Be Completed by Physician/Medical Examiner

To Be Completed by Physician/Medical Examiner

To Be Completed by Physician/Medical Examiner

To Be Completed by Physician/Medical Examiner

To Be Completed by Physician/Medical Examiner

*Handwritten signature or scribble*

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39700

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LEILA INEZ STOFFER

2. Date of Death

Month Day Year  
December 13 1997

3. Time of Death

9:44 AM

4a. Facility Name (If not institution, give street and number)

REEDERS MEMORIAL HOME

4b. City, Town, or Location of Death

BOONSBORO

4c. County of Death

WASHINGTON

5. Social Security Number

217-16-2984

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
NOV. 19, 1905

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State  
MARYLAND

10b. County

WASHINGTON

10c. City, Town or Location

BOONSBORO

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

141 SOUTH MAIN STREET

10f. Zip Code

21713

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
WHITE15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
8

College (1-4 or 5+)

16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

SHEET METAL WORKER

16b. Kind of Business/Industry

AIRCRAFT MANUFACTURING

17. Father's Name (First, Middle, Last)

DANIEL W. MICHAEL

18. Mother's Name (First, Middle, Maiden Surname)

LETTIE V. EAKLE

19a. Informant's Name/Relationship (Type, Print)

ANITA S. WORLEY/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10500 ROCKVILLE PIKE, #715, ROCKVILLE, MD 20852

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

BOONSBORO CEMETERY

Date

12/17/97

20c. Location - City or Town, State

BOONSBORO, MARYLAND

21. Signature of Funeral Service Licensee

Paul M. Dean

22. Name and Address of Facility

BAST FUNERAL HOME

7606 Old National Pike  
Boonsboro, MD 2171323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)e. ASPIRATION PNEUMONIA  
Due to (or as a consequence of):b. GI BLEED  
Due to (or as a consequence of):c. A-FIBRILLATION  
Due to (or as a consequence of):d. CAD  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Syed, Z. M.D.

29c. License number

D52055

29d. Date signed (Month, Day, Year)

12/13/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Zubair Syed 130 W. High Street, Hancock, MD

(301) 678-7256

31. Date filed (Month, Day, Year)

DEC 15 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
RegistrarName: Leila Inez Stoffer  
Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 97 39701

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

REBECCA ANN TAYLOR

2. Date of Death

Month Day Year  
December 19 1997 8:03P

3. Time of Death

Funeral  
Director

4e. Facility Name (If not institution, give street and number)

The Memorial Hospital

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

5. Social Security Number

215-44-6060

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

53 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
07/27/44

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Dorchester

10c. City, Town or Location

Federalsburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6628-3 Eldorado Road

10f. Zip Code

21632

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Samuel Cohey

18. Mother's Name (First, Middle, Maiden Surname)

Elsie Mae Quillen

19a. Informant's Name/Relationship (Type, Print)

Jimmy Taylor/Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6628-3 Eldorado Rd., Federalsburg, MD 21632

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Cambridge Crematory 12/22

Date

20c. Location - City or Town, State

Cambridge, MD

21. Signature of Funeral Service Licensee

Michael F. Eskow

22. Name and Address of Facility

Framptom-Hawkins-Eskow Funeral Home  
PO Box 43, Federalsburg, MD 2163223e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Cerebrovascular accident

Due to (or as a consequence of):

b. Diabetes mellitus

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death9 days  
years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atherosclerosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24e. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and Title of Certifier

Michael F. Eskow

29c. License number

D37857

29d. Date signed (Month, Day, Year)

12/20/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David H. Smith, M.D., 509 Idlewild Ave., Easton, MD 21601

31. Date filed (Month, Day, Year)

DEC 22 1997

32. Registrar's Signature

John Anderson Randall

State  
RegistrarRebecca Taylor  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: if item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39702

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

HELEN BEATRICE TRACEY

2. Date of Death  
Month Day Year  
DEC 13, 19973. Time of Death  
8:15 PM

4a. Facility Name (If not institution, give street and number)

5406 ARCADIA AVENUE

4b. City, Town, or Location of Death

UPPERCO

4c. County of Death

BALTIMORE

5. Social Security Number

218-32-9820

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
APR 27, 1915

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

UPPERCO

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5406 ARCADIA AVENUE

10f. Zip Code

21155

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

NOAH IRVIN RILL

18. Mother's Name (First, Middle, Maiden Surname)

LULU ANNA DAVIDSON

19a. Informant's Name/Relationship (Type, Print)

LAWRENCE R. TRACEY, HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5406 ARCADIA AVE, UPPERCO, MD 21155

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WESLEY CEMETERY

Date

12/17

20c. Location - City or Town, State

HAMPSTEAD, MD

21. Signature of Funeral Service Licensee

Stevens W. Eline

22. Name and Address of Facility

ELINE FUNERAL HOME

934 SOUTH MAIN ST, HAMPSTEAD, MD 21074

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

myocardial infarct

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

minutes

b.

ASCVD

Due to (or as a consequence of):

years

c.

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Insulin Dependent Diabetes mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Stevens W. Eline

29c. License number

D33165

29d. Date signed (Month, Day, Year)

12/15/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Steven Shaffer 2111 Hanover Pk. Hampstead md 21074

31. Date filed (Month, Day, Year)

DEC 16 1997

32. Registrar's Signature

John Andrew Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39703

|   |   |   |   |  |   |   |  |  |  |  |
|---|---|---|---|--|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>IDA TORREZ  |   |   |  | 2. Date of Death<br>Month Day Year<br>DECEMBER 16, 1997   |   |  |  | 3. Time of Death<br>9:20PM   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>HEBREW HOME OF GREATER WASHINGTON   |   |   |  | 4b. City, Town, or Location of Death<br>ROCKVILLE   |   |  |  | 4c. County of Death<br>MONTGOMERY  |  |
| Funeral<br>Director   | 5. Social Security Number<br>350-03-8570  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>83 Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br>SEPT. 18, 1914                                |  | 9. Birthplace (State or Foreign Country)<br>ILLINOIS   |  |
|   | Usual Residence of Decedent   |   |   |  |   |   |  |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br>MARYLAND  |   | 10b. County<br>MONTGOMERY   |  | 10c. City, Town or Location<br>ROCKVILLE  |   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|   | 10e. Street and Number<br>6105 MONTROSE ROAD  |   |   |  | 10f. Zip Code<br>20852  |   | 10g. Citizen of What Country?<br>UNITED STATES                                       |  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE   |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4or 5+)   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>SALES  |   |  | 16b. Kind of Business/Industry<br>RETAIL   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>DAVID LEDERMAN   |   |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>MINI (UNKNOWN) |  |  |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>MORTON KONDRACK (SON-IN-LAW)  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2230 CALIFORNIA ST., NW-WASHINGTON, D.C. 20008   |   |  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>LOCKPORT CEMETERY   |  | Date<br>12/19/97  |   | 20c. Location - City or Town, State<br>LOCKPORT, ILLINOIS                            |  |  |  |
|   | 21. Signature of Funeral Service Licensee   |   |   |  | 22. Name and Address of Facility<br>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.<br>1170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND  |   |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Cerebrovascular accident<br>Due to (or as a consequence of):<br>b. Hypertension<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |   |   |  |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Atrial fibrillation, ischemic cardiomyopathy, anemia  |   |   |  |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |
| State Registrar   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |   |  |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |   |  |   |   |  |  |  |  |
|   | 29b. Signature and title of certifier<br>B. Binkley MD  |   |   |  | 29c. License number<br>D 23958  |   | 29d. Date signed (Month, Day, Year)<br>12/17/97                                      |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>BURT FELDMAN - 6121 MONTROSE ROAD - ROCKVILLE, MARYLAND 20852 |   |   |   |  |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>DEC 19 1997  |   | 32. Registrar's Signature<br>Julia Davidson-Randall |   |  |   |   |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39704

Physician  
/Medical  
Examiner

Funeral  
Director

|  |  |  |  |   |                                |   |  |  |  |
|--|--|--|--|---|--------------------------------|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Lynn Margaret Thompson</b>  |  |  |  | 2. Date of Death<br>Month Day Year<br><b>DECEMBER 11, 1997</b>  |                                | 3. Time of Death<br><b>7:05AM</b>   |  |  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>I-495 &amp; TEMPLE HILLS ROAD</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>OXEN HILL</b>  |                                | 4c. County of Death<br><b>PRINCE GEORGES</b>  |  |  |  |
| 5. Social Security Number<br><b>Unknown</b>  |  | 6. Sex<br><b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>  | 7. Age (In yrs. last birthday)<br><b>27</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>March 17, 1970</b>  |  |  |  |
| 9. Birthplace (State or Foreign Country)<br><b>Washington, D.C.</b>  |  |  |  |   |                                |   |  |  |  |
| Usual Residence of Decedent  |  |  |  |   |                                |   |  |  |  |
| 10a. State<br><b>N/A</b>   |  | 10b. County<br><b>N/A</b>  |  | 10c. City, Town or Location<br><b>Washington, D.C.</b>  |                                | 10d. Inside City Limits<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>   |  |  |  |
| 10e. Street and Number<br><b>1905 15th Street, N.W.</b>  |  |  |  | 10f. Zip Code<br><b>20009</b>   |                                | 10g. Citizen of What Country?<br><b>United States</b>   |  |  |  |
| 11. Marital Status<br><b>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married</b><br><b>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b><br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</b> |                                | 14. Race - American Indian, Black, White, etc.<br><b>Specify: Black</b>   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 11</b><br><b>College (1-4or 5+)</b>  |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Never Employed</b>  |                                | 16b. Kind of Business/Industry<br><b>N/A</b>  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Michael C. Thompson</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marva Grasty</b>  |                                |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Delia Thompson / Sister</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6101 16th Street, N.W., Washington, D.C. 20011</b>  |                                |   |  |  |  |
| 20a. Method of Disposition<br><b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State</b><br><b>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Maryland National Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>Laurel, Maryland</b>  |                                | 20d. Date<br><b>12/16/97</b>  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |  |  | 22. Name and Address of Facility<br><b>McGuire Funeral Service, Inc.</b><br><b>7400 Georgia Ave. N.W., Washington, D.C. 20012</b>   |                                |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Multiple Injuries</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d.</b> |  |  |  |   |                                |   |  | Approximate Interval Between Onset and Death |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |                                | 23b. Did tobacco use contribute to the cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</b>   |  |  |  |
| 25. Was case referred to medical examiner?<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>   |  |  |  |   |                                | 26. Place of Death (Check only one)<br>Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) ROADWAY</b> |  |  |  |
| 27. Manner of Death<br><b>1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b><br><b>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined</b>   |  | 28a. Date of Injury (Month, Day Year)<br><b>12/11/1997</b>   |  | 28b. Time of Injury<br><b>4:00AM</b>  |                                | 28c. Injury at Work?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>  |  |  |  |
| 28d. Describe how Injury occurred<br><b>PEDESTRIAN STRUCK BY AUTO</b>  |  |  |  | 28e. Location (Street and Number or Rural Route Number, City, Town, State)<br><b>ROADWAY</b><br><b>INTERSTATE 495 &amp; TEMPLE HILLS ROAD PRINCE GEORGES COUNTY</b>                                     |                                |   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City, Town, State)<br><b>ROADWAY</b><br><b>INTERSTATE 495 &amp; TEMPLE HILLS ROAD PRINCE GEORGES COUNTY</b>  |  |  |  |   |                                |   |  |  |  |
| 29a. Certifier (Check only one)<br><b>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>  |  |  |  |   |                                |   |  |  |  |
| 29b. Signature and title of certifier<br><br><b>DENNIS J. CHUTE M.D.</b>  |  |  |  | 29c. License number<br><b>O.C.M.E.</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>DECEMBER 11, 1997</b>   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DENNIS J. CHUTE M.D. 111 Penn Street, Baltimore, Maryland 21201</b>   |  |  |  |   |                                |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 18 1997</b>  |  |  |  | 32. Registrar's Signature<br>  |                                |   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

3



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 39705

Physician  
/Medical  
Examiner

Funeral  
Director

|  |    |  |  |  |                                |   |  |   |    |                              |  |    |                        |          |    |  |  |    |  |  |
|--|----|--|--|--|--------------------------------|---|--|---|----|------------------------------|--|----|------------------------|----------|----|--|--|----|--|--|
| 1. Decedent's Name (First, Middle, Last)<br>Francis A. Thompson II   |    |  |  | 2. Date of Death<br>Month Day Year<br>December 18, 1997  |                                | 3. Time of Death<br>12:10 AM  |  |   |    |                              |  |    |                        |          |    |  |  |    |  |  |
| 4a. Facility Name (If not institution, give street and number)<br>4017 Jeffry Street   |    |  |  | 4b. City, Town, or Location of Death<br>Silver Spring  |                                | 4c. County of Death<br>Montgomery   |  |   |    |                              |  |    |                        |          |    |  |  |    |  |  |
| 5. Social Security Number<br>084-24-5751   |    | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br>67 Yrs.                | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br>Oct. 17, 1930  |  |   |    |                              |  |    |                        |          |    |  |  |    |  |  |
| 9. Birthplace (State or Foreign Country)<br>Wisconsin  |    |  |  |  |                                |   |  |   |    |                              |  |    |                        |          |    |  |  |    |  |  |
| Usual Residence of Decedent  |    |  |  |  |                                |   |  |   |    |                              |  |    |                        |          |    |  |  |    |  |  |
| 10a. State<br>MD   |    | 10b. County<br>Montgomery  |  | 10c. City, Town or Location<br>Silver Spring   |                                | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No        |  |   |    |                              |  |    |                        |          |    |  |  |    |  |  |
| 10e. Street and Number<br>4017 Jeffry Street   |    |  |  | 10f. Zip Code<br>20906   |                                | 10g. Citizen of What Country?<br>USA  |  |   |    |                              |  |    |                        |          |    |  |  |    |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |    | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1954 |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  |   |    |                              |  |    |                        |          |    |  |  |    |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>2  |    | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Account Executive                             |  | 16b. Kind of Business/Industry<br>Sales  |                                |   |  |   |    |                              |  |    |                        |          |    |  |  |    |  |  |
| 17. Father's Name (First, Middle, Last)<br>Francis Arthur Thompson   |    |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Evelyn Plante   |                                |   |  |   |    |                              |  |    |                        |          |    |  |  |    |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Suzanne Thompson / Wife  |    |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4017 Jeffry Street, Silver Spring, MD 20906   |                                |   |  |   |    |                              |  |    |                        |          |    |  |  |    |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |    | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Gate of Heaven Cemetery  |  | Date<br>12/20/97   |                                | 20c. Location - City or Town, State<br>Silver Spring, MD  |  |   |    |                              |  |    |                        |          |    |  |  |    |  |  |
| 21. Signature of Funeral Service Licensee<br>Eric S. Scott   |    | 22. Name and Address of Facility<br>Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901                                |  |  |                                |   |  |   |    |                              |  |    |                        |          |    |  |  |    |  |  |
| 23a. Pert. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |    |  |  |  |                                |   |  |   |    |                              |  |    |                        |          |    |  |  |    |  |  |
| <table border="0"> <tr> <td rowspan="4">                 Immediate Cause (Final disease or condition resulting in death)<br/><br/>                 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last             </td> <td>a.</td> <td>CANCER - Metastatic to Liver</td> <td>Approximate Interval Between Onset and Death<br/>4 months</td> </tr> <tr> <td>b.</td> <td>CARCINOMA of Esophagus</td> <td>6 months</td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> |    |  |  |  |                                |   |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | CANCER - Metastatic to Liver | Approximate Interval Between Onset and Death<br>4 months | b. | CARCINOMA of Esophagus | 6 months | c. |  |  | d. |  |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | a. | CANCER - Metastatic to Liver   | Approximate Interval Between Onset and Death<br>4 months |  |                                |   |  |   |    |                              |  |    |                        |          |    |  |  |    |  |  |
|  | b. | CARCINOMA of Esophagus   | 6 months   |  |                                |   |  |   |    |                              |  |    |                        |          |    |  |  |    |  |  |
|  | c. |  |  |  |                                |   |  |   |    |                              |  |    |                        |          |    |  |  |    |  |  |
|  | d. |  |  |  |                                |   |  |   |    |                              |  |    |                        |          |    |  |  |    |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |    |  |  |  |                                | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |   |    |                              |  |    |                        |          |    |  |  |    |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |    |  |  |  |                                |   |  |   |    |                              |  |    |                        |          |    |  |  |    |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |    |  |  |  |                                |   |  |   |    |                              |  |    |                        |          |    |  |  |    |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |    |  |  |  |                                |   |  |   |    |                              |  |    |                        |          |    |  |  |    |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |    | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br>M   |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                      |  |   |    |                              |  |    |                        |          |    |  |  |    |  |  |
| 28d. Describe how injury occurred  |    | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |                                |   |  |   |    |                              |  |    |                        |          |    |  |  |    |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |    |  |  |  |                                |   |  |   |    |                              |  |    |                        |          |    |  |  |    |  |  |
| 29b. Signature and title of certifier<br>Eugene P. Libee MD  |    | 29c. License number<br>D08470  |  | 29d. Date signed (Month, Day, Year)<br>Dec 18, 1997  |                                |   |  |   |    |                              |  |    |                        |          |    |  |  |    |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>EUGENE P. LIBEE MD 10400 CONNECTICUT AVE KENSINGTON MD 20891   |    |  |  |  |                                |   |  |   |    |                              |  |    |                        |          |    |  |  |    |  |  |
| 31. Date filed (Month, Day, Year)<br>DEC 19 1997   |    | 32. Registrar's Signature<br>Julia Davidson-Randall  |  |  |                                |   |  |   |    |                              |  |    |                        |          |    |  |  |    |  |  |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 39706**  
**Certificate of Death**

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

**JAMES TWYMAN**

2. Date of Death  
Month Day Year

**Dec 12 97**

3. Time of Death

**6:35 PM**

4a. Facility Name (If not institution, give street and number)

**MONTGOMERY GENERAL HOSPITAL**

4b. City, Town, or Location of Death

**OLNEY**

4c. County of Death

**MONTGOMERY**

5. Social Security Number

**214-30-1294**

6. Sex

**1 ☒ M 2 ☐ F**

7. Age (In yrs. last birthday)

**61** Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

**Apr. 24, 1936**

9. Birthplace (State or Foreign Country)

**Maryland**

Usual Residence of Decedent

10a. State

**MD**

10b. County

**Montgomery**

10c. City, Town or Location

**Silver Spring**

10d. Inside City Limits

**1 ☐ Yes 2 ☒ No**

10e. Street and Number

**3028 Hewitt Avenue**

10f. Zip Code

**20906**

10g. Citizen of What Country?

**U.S.A.**

11. Marital Status

**1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced**

12. Was Decedent Ever In U.S. Armed Forces?

**1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:**

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

**1 ☐ Yes 2 ☒ No Specify:**

14. Race - American Indian, Black, White, etc.

**Specify: Black**

15. Decedent's Education (Specify only highest grade completed)

**Elementary/Secondary (0-12)  
12th**

**Collage (1-4or 5+)**

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

**Stone Mason**

16b. Kind of Business/Industry

**Construction**

17. Father's Name (First, Middle, Last)

**Frank Twyman**

18. Mother's Name (First, Middle, Maiden Surname)

**Mary A. Wilson**

19a. Informant's Name/Relationship (Type, Print)

**Katherine E. Twyman (Wife)**

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

**3001 Hewitt Ave., #387, Silver Spring, MD 20906**

20a. Method of Disposition

**1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)**

20b. Place of Disposition (Name of cemetery, crematory or other place)

**Lincoln Park Cem. 12/19/97 Rockville, MD**

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

**SNOWDEN FUNERAL HOME, P.A.  
ROCKVILLE, MD 20850**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

**e. Cerebrovascular accident**

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

**1 hr.**

**b. Hypertension**

Due to (or as a consequence of):

**years**

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

**c. Due to (or as a consequence of):**

**d. Due to (or as a consequence of):**

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

**1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown**

24a. Was an autopsy performed?

**1 ☐ Yes 2 ☒ No**

24b. Were autopsy findings available prior to completion of cause of death?

**1 ☐ Yes 2 ☒ No**

25. Was case referred to medical examiner?

**1 ☒ Yes 2 ☐ No**

Hospital:

**1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA**

26. Place of Death (Check only one)

Other:

**4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)**

27. Manner of Death

**1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined**

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

**M 1 ☐ Yes 2 ☐ No**

28c. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

**1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.**

29b. Signature and title of certifier

*[Signature]*

29c. License number

**208546**

29d. Date signed (Month, Day, Year)

**Dec 12 1997**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**John Tauber 8718 Wisconsin Ave Bethesda**

31. Date filed (Month, Day, Year)

**DEC 17 1997**

32. Registrar's Signature

*[Signature]*

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39707

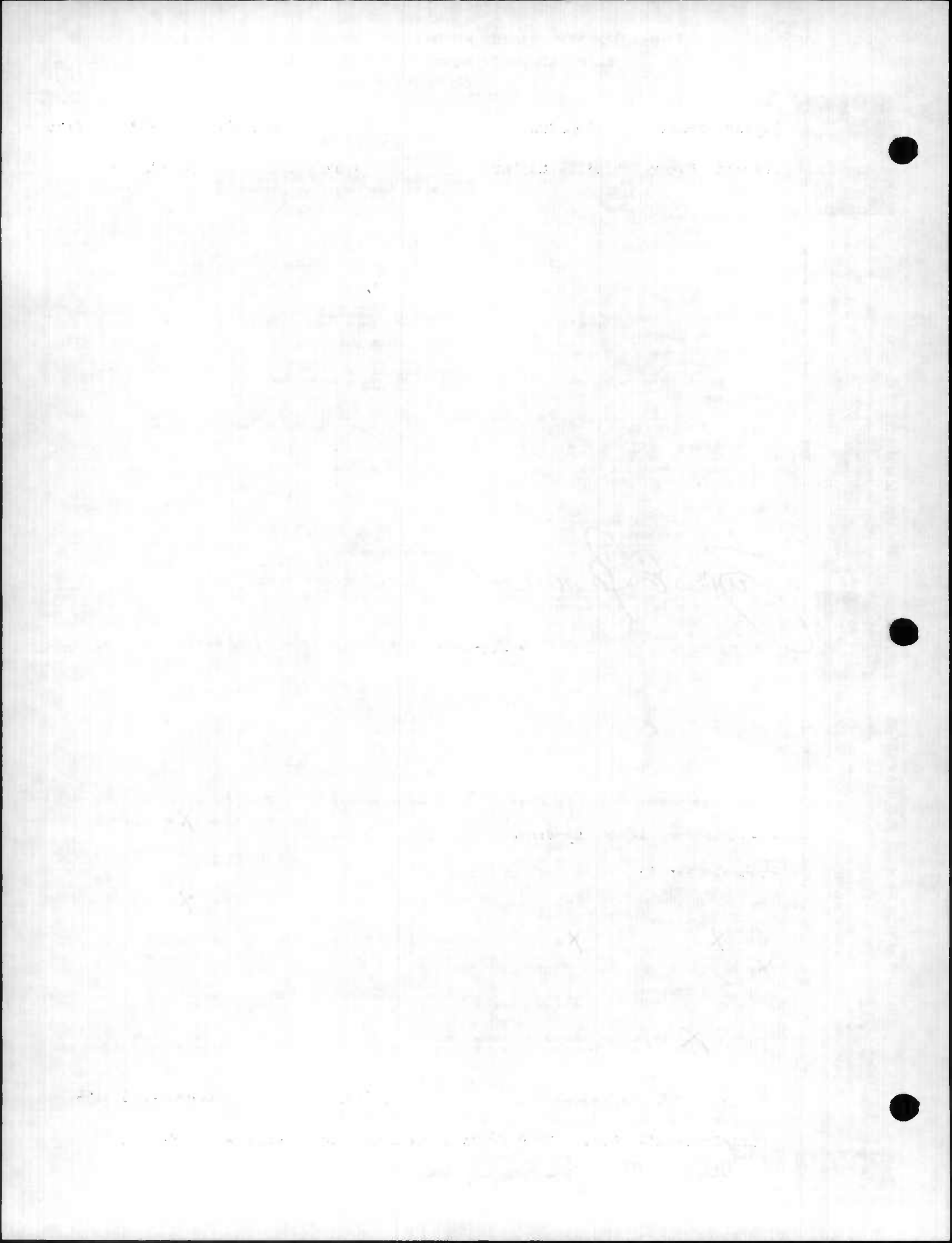
|   |  |                                      |   |   |  |   |  |  |  |  |
|---|--|--------------------------------------|---|---|--|---|--|--|--|--|
| <b>Physician<br/>/Medical<br/>Examiner</b>  | 1. Decedent's Name (First, Middle, Last)<br><b>Taylor Renee THOMPSON</b>                                 |                                      |   |   |  | 2. Date of Death<br>Month Day Year<br><b>December 5, 1997</b> |  | 3. Time of Death<br><b>12:55 pm</b>  |  |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>Franklin Square Hospital Center</b> |                                      |   |   |  | 4b. City, Town, or Location of Death<br><b>Rosedale</b>       |  | 4c. County of Death<br><b>Baltimore</b>  |  |  |
| <b>Funeral<br/>Director</b>   | 5. Social Security Number<br><b>n/a</b>  |                                      | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>Yrs. Months Days<br><b>0 11</b>  |   | 8. Date of Birth (Month, Day, Year)<br><b>Nov 24, 1997</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>        |  |
|   | Usual Residence of Decedent  |                                      |   |   |  |   |  |  |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Baltimore City</b> |   | 10c. City, Town or Location<br><b>Baltimore</b> |  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| 10e. Street and Number<br><b>6206 Radecke Avenue</b>  |  |                                      |   |   | 10f. Zip Code<br><b>21206</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |                                      | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>0</b> College (1-4or 5+)  |  |                                      | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>n/a</b>   |   |  | 16b. Kind of Business/Industry<br><b>n/a</b>                  |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Matthew Allen Thompson</b>  |  |                                      |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Denise Lynn Lazzara</b>  |   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Matthew A. Thompson/father</b>   |  |                                      |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6206 Radecke Ave., Baltimore, MD 21206</b>   |   |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |                                      | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Mem. Park</b>   |   | Date<br><b>Dec 8 1997</b>  |   | 20c. Location - City or Town, State<br><b>Timonium, MD</b>   |  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |                                      |   |   | 22. Name and Address of Facility<br><b>Barranco &amp; Sons, P.A. Severna Park Funeral Home<br/>495 Gov. Ritchie Hwy., Severna Park, MD 21146</b>   |   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <u>Extreme Prematurity</u><br>Due to (or as a consequence of):<br><br>b. _____<br>Due to (or as a consequence of):<br><br>c. _____<br>Due to (or as a consequence of):<br><br>d. _____<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                                      |   |   |  |   |  |  | Approximate Interval Between Onset and Death<br><br><b>11 days</b> |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><u>Respiratory Distress Syndrome</u><br><br><u>Probable Sepsis</u>  |  |                                      |   |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |  |
|   |  |                                      |   |   |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |
|   |  |                                      |   |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                                      | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide   |  |                                      | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred                                  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |                                      |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |                                      |   |   |  |   |  |  |  |  |
| 29b. Signature and title of certifier<br>  |  |                                      |   |   | 29c. License number<br><b>D22511</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>December 5, 1997</b>   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Sita Kottapalli M.D. 9000 Franklin Square Drive Baltimore, MD 21237</b>  |  |                                      |   |   |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 11 1997</b>   |  |                                      |   |   | 32. Registrar's Signature<br>   |   |  |  |  |  |

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 39708

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ANDREA MICHELLE TUCKER

2. Date of Death

Month Day Year  
DECEMBER 11, 1997

3. Time of Death

10:08AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

CALVERT MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

PRINCE FREDERICK

4c. County of Death

CALVERT

5. Social Security Number

579-76-8975

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

40

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

9-24-57

9. Birthplace (State or Foreign Country)

Wash., D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Calvert

10c. City, Town or Location

Prince Frederick

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

415 Push Shaw Station Road

10f. Zip Code

20689

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

+4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cook

16b. Kind of Business/Industry

Private Industry

17. Father's Name (First, Middle, Last)

Levi Tucker

18. Mother's Name (First, Middle, Maiden Surname)

Daisy Harris

19a. Informant's Name/Relationship (Type, Print)

Denita Tucker/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6130 13th St., N.W. Washington, D.C. 20011

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Cemetery

Date

12/16/97

20c. Location - City or Town, State

Landover, Md.

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Frazier's Funeral Home  
389 Rhode Island Ave., NW Wash., DC 20001

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

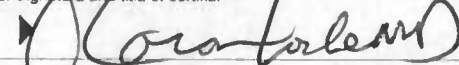
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

DECEMBER 12, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. L. LOKEN, MD 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

DEC 16 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

Handwritten text, possibly a signature or title, located in the middle of the page.

Handwritten signature or initials, located in the bottom right area of the page.

Handwritten text at the bottom of the page, possibly a date or reference number.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 39709

AMENDED # 9. PER F.H. 12-23-97 PGC cr

## Certificate of Death

Reg. No.

|   |  |  |  |   |  |  |  |   |
|---|--|--|--|---|--|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>NATHANIEL THOMPSON</b>                                  |  |  |   | 2. Date of Death<br>Month Day Year<br><b>December 10, 1997</b> |  | 3. Time of Death<br><b>6:45 PM</b>   |   |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>WASHINGTON ADVENTIST HOSPITAL</b> |  |  |   | 4b. City, Town, or Location of Death<br><b>Takoma Park</b>     |  | 4c. County of Death<br><b>Montgomery</b>   |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>237-20-9276</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>80 Yrs.</b> | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                                 | 8. Date of Birth (Month, Day, Year)<br><b>May 19, 1917</b>                       |  | 9. Birthplace (State or Foreign Country)<br><b>Tennessee North Carolina</b> |
|   | Usual Residence of Decedent  |  |  |   |  |  |  |   |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Prince Georges</b>   |  | 10c. City, Town or Location<br><b>Hyattsville</b>   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
| 10e. Street and Number<br><b>1114 Burketon Road</b>   |  |  |  | 10f. Zip Code<br><b>20783</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                   |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1944-46</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4th</b> College (1-4 or 5+)   |  |  |  | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Elevator Operator</b>   |  |  | 16b. Kind of Business/Industry<br><b>Rings Building</b>  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Samuel Thompson</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Maudie Hilliard</b>   |  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Fay Ellen Thompson-Wife</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1114 Burketon Rd. Hyattsville, MD 20783</b>   |  |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Maryland National Cemetery</b>   |  |  | 20c. Location - City or Town, State<br><b>12-15 Laurel, MD</b>                                 |   |
| 21. Signature of Funeral Service Licensee<br><b>J. P. Marshall</b>  |  |  |  | 22. Name and Address of Facility<br><b>Marshall's Funeral Home, Inc.<br/>4217 9th Street N W Washington, DC 20011</b>   |  |  |  |   |
| 23a. Per 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>e. <b>Ventricular Fibrillation</b><br>Due to (or as a consequence of):<br>b. <b>Congestive Cardiomyopathy</b><br>Due to (or as a consequence of):<br>c. <b>Acute Ischemic Heart Disease</b><br>Due to (or as a consequence of):<br>d.<br><br>Approximate Interval Between Onset and Death<br><b>&lt; 1 hr</b><br><b>approx 5 yrs</b><br><b>approx 5 yrs</b> |  |  |  |   |  |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Renal Failure</b>  |  |  |  |   |  |  |  |   |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |  |  |   |  |  |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28d. Describe how injury occurred   |  |  |  |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |   |
| 29b. Signature and title of certifier<br><b>Gregory Fisher, M.D.</b>  |  |  |  | 29c. License number<br><b>013818</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>12/12/97</b>                           |  |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Gregory Fisher, M.D. 15225 Shady Grove Road, Rockville, MD</b>   |  |  |  |   |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>DEC 16 1997</b>   |  |  |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

10

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

11/11/11  
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 39710**  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SHARI ANN TALLEY

2. Date of Death

Month Day Year  
December 11, 1997

3. Time of Death

2:45AM

4a. Facility Name (If not institution, give street and number)

Doctors' Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

217-84-7040

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

36 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
09-27-1961

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Lanham

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9100 Wallace Road

10f. Zip Code

20706

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12th

College (1-4 or 5+)  
College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Floor Manager

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Alfred W. Jones

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Hall

19a. Informant's Name/Relationship (Type, Print)

Alphonso Talley/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9100 Wallace Road, Lanham, Maryland 20706

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Park Maryland National Mem.

Date

12/16 1997

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

Nancy A. Perentis

22. Name and Address of Facility

J. B. JENKINS FUNERAL HOME  
7474 Landover Road, Landover, Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiogenic Shock & complete heart block 2 hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Acute inferior wall Myocardial infarction 4 hours

Due to (or as a consequence of):

c. Coronary artery disease years

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Carcinoma of breast with Chemotherapy  
Anemia

Hodgkins disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Thomas R. Ko, MD

29c. License number

D 22111

29d. Date signed (Month, Day, Year)

Dec 11 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5100 GOODLUCK ROAD SUITE 302 LANHAM MARYLAND 20706

31. Date filed (Month, Day, Year)

DEC 16 1997

32. Registrar's Signature

[Signature]

State Registrar

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

10

R TALLEY Shannon  
Baltimore, Maryland 21215-0020



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

FISSAHAYE TELLA

State of Maryland / Department of Health and Mental Hygiene

Items: 23 part I, 27 per MEO G-755

Certificate of Death

Reg. No.

97 39711

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>FISSAHAYE TELLA</b>  |  | 2. Date of Death<br>Month <b>DEC.</b> Day <b>22,</b> Year <b>1997</b>   |   | 3. Time of Death<br><b>1735 PM</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>12001 GORDON AVENUE</b>  |  |   | 4b. City, Town, or Location of Death<br><b>BELTSVILLE</b>   |  | 4c. County of Death<br><b>PRINCE GEORGES</b>   |
| 5. Social Security Number<br><b>214-51-2942</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>43</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>MAY 15 1954</b>  |
| 9. Birthplace (State or Foreign Country)<br><b>ERITREA</b>  |  |   |   |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>PRINCE GEORGES</b>  |   | 10c. City, Town or Location<br><b>BELTSVILLE</b>   |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>12001 GORDON AVENUE</b>  |   |  |  |
| 10f. Zip Code<br><b>20705</b>   |  | 10g. Citizen of What Country?<br><b>ERITREA</b>   |   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>1</b> Collega (1-4or 5+) <b>1</b>   |   |  |  |
| 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>UNEMPLOYED</b>   |  | 16b. Kind of Business/Industry<br><b>NONE</b>   |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>KIDRNE TELLA</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>UNAVAILABLE</b>   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>WELDE MEZGHEBE-BROTHER N_LAW</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12001 GORDON AVENUE, BELTSVILLE, MD 20705</b> |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>FAMILY CEMETERY</b>  |   | 20c. Location - City or Town, State<br><b>DEC. 30 97 ASMARA ERITREA</b>  |  |
| 21. Signature of Funeral Service Licensee<br> <b>276</b>  |  | 22. Name and Address of Facility<br><b>W.H. BACON FUNERAL HOME INC.<br/>3447 14TH STREET, NW WASH, D.C. 20010</b>   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>a. CARDIAC ARRHYTHMIA</b><br>Due to (or as a consequence of):<br><br><b>b.</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b>                            |  |   |   |  | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>O.C.M.E</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>DEC. 23, 1997</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>J. L. LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201</b>   |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 26 1997</b>   |  | 32. Registrar's Signature<br>  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39712

|   |   |   |  |  |  |  |  |  |
|---|---|---|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>HAFIZ UDDIN</b>                                  |   |  |  | 2. Date of Death<br>Month <b>12</b> Day <b>15</b> Year <b>97</b> |  | 3. Time of Death<br><b>12:20am</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>PRINCE GEORGE HOSPITAL</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>CHEVERLY</b>          |  | 4c. County of Death<br><b>PRINCE GEORGE</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>218-35-1373</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>55</b> Yrs.                 |  | 8. Date of Birth (Month, Day, Year)<br><b>8-19-42</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Bangladesh</b>                                   |   |  |  |  |  |  |  |
| Usual Residence of Decedent   |   |   |  |  |  |  |  |  |
| 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Prince George</b>   |  | 10c. City, Town or Location<br><b>LANDOVER</b>   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>6712 VERMONT CT.</b>   |   |   |  | 10f. Zip Code<br><b>20785</b>  |  | 10g. Citizen of What Country?<br><b>Bangladesh</b>   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Asian</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>TEACHER</b>  |  |  | 16b. Kind of Business/Industry<br><b>EDUCATION</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>WOAZ UDDIN</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>FATEMA BEGUM</b>   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>MOHAMED ZAMAN</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6712 Vermont Ct., Landover, Md. 20785</b>  |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GEO. Washington Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>12-16-97 Adelphi, Md.</b>  |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |   |   |  | 22. Name and Address of Facility<br><b>Universal Mortuary Inc.<br/>411 Kennedy St, N.W., Washington, D.C.</b>  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Myocardial Infarction</b><br>Due to (or as a consequence of):<br><b>b. High Blood Pressure</b><br>Due to (or as a consequence of):<br><b>c. Chronic Renal Failure</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>{ Hypoxic Encephalopathy and Coma, Pulmonary Failure</b> |   |   |  |  |  |  |  |  |
| Approximate Interval Between Onset and Death<br><b>6 days</b><br><b>10 years</b><br><b>2 years</b>  |   |   |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypoxic Encephalopathy and Coma, Pulmonary Failure</b>   |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
|   |   |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred  |
|   |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |   |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br><b>[Signature] M.D.</b>  |   |   |  | 29c. License number<br><b>00052058</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>12-15-97</b>   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ARSHAD P. CHEEMA, M.D. Resident Doctor at PRINCE GEORGES HOSP.</b>   |   |   |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 17 1997</b>   |   | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

(2)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39713

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ANNE VORZIMER

2. Date of Death

Month Day Year  
DECEMBER 13 1997

3. Time of Death

10:30 PM

4a. Facility Name (If not institution, give street and number)

HEBREW HOME OF GREATER WASHINGTON

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

104 16 3414

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

96

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
APRIL 15, 1901

9. Birthplace (State or Foreign Country)

NY

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6121 MONTROSE ROAD

10f. Zip Code

20852

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

SAMUEL GLASSER

18. Mother's Name (First, Middle, Maiden Surname)

FRANCES (UNKNOWN)

19a. Informant's Name/Relationship (Type, Print)

VIVIAN SHAW (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

140 E. 56TH STREET, NEW YORK, NY 10022

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT COMFORT CEMETERY

Date

12/15/97

20c. Location - City or Town, State

ALEXANDRIA, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DANZANSKY-GOLDBERG MEMORIAL CHAPELS INC  
1170 ROCKVILLE PIKE, ROCKVILLE MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CANCER OF BREAST WITH METASTASIS

Approximate Interval Between Onset and Death

MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 36552

29d. Date signed (Month, Day, Year)

DECEMBER 13 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P. TALWAR 6121 MONTROSE ROAD ROCKVILLE MD. 20852

31. Date filed (Month, Day, Year)

DEC 16 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

20



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39714

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

FANNIE VODENLITCH

2. Date of Death

Month 12 Day 11 Year 1997

3. Time of Death

2:30 am

4a. Facility Name (If not institution, give street and number)

SUBURBAN HOSPITAL

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

062-24-7730

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

JANUARY 9 1905

9. Birthplace (State or Foreign Country)

BOSNIA

Usual Residence of Decedent

10a. State

FL

10b. County

BROWARD

10c. City, Town or Location

HALLANDALE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1904 S. OCEAN DRIVE

10f. Zip Code

33009

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

ISAAC FRITZHAND

18. Mother's Name (First, Middle, Maiden Surname)

ANNA BREINER

19a. Informant's Name/Relationship (Type, Print)

NADA SCALETTAR - DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11921 TILDENWOOD DRIVE, N. BETHESDA MD 20852

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Menorah Gardens

Date

12-14-97

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Danzansky-Goldberg Mem. Chapels, Inc.

1170 Rockville Pike, Rockville, MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. sepsis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

18 hrs

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. pelvic abscess

Due to (or as a consequence of):

unknown

c. sigmoid diverticular rupture, possible

Due to (or as a consequence of):

unknown

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

coronary heart disease with ischemic

cardiomyopathy

chronic atrial fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Thomas G. Sinderson, MD

29c. License number

019144

29d. Date signed (Month, Day, Year)

DEC. 11, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

THOMAS G. SINDERSON, MD 6410 ROCKLEDGE DR #200, BETHESDA MD 20817

31. Date filed (Month, Day, Year)

DEC 16 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 39715

## Certificate of Death

Reg. No.

|   |   |   |   |  |  |  |  |  |
|---|---|---|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>GEORGE HOWARD WEAVER</b>   |   |   |  | 2. Date of Death<br>Month <b>DEC.</b> Day <b>11</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>1:30 AM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>GOLDEN AGE GUEST HOME</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>SYKESVILLE</b>  |  | 4c. County of Death<br><b>CARROLL</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>217-16-2651</b>   |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>NOV. 18, 1917</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |   | 10a. State<br><b>MD.</b>  |  | 10b. County<br><b>CARROLL</b>  |  | 10c. City, Town or Location<br><b>WESTMINSTER</b>  |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 10e. Street and Number<br><b>511 MARK DR.</b>   |  | 10f. Zip Code<br><b>21157</b>  |  | 10g. Citizen of What Country?<br><b>USA.</b>   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>ACCOUNTANT</b>                        |  | 16b. Kind of Business/Industry<br><b>OIL COMPANY</b>   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>GEORGE ALBERT WEAVER</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ETTA RHOTEN</b>  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>MARY WEAVER - WIFE</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>511 MARK DR., WESTMINSTER, MD. 21157</b>   |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>PLEASANT GROVE CEM.</b>  |  | Date<br><b>12/13/97</b>  |  | 20c. Location - City or Town, State<br><b>UPPERCO, MD.</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br><b>FLETCHER FUNERAL HOME<br/>254 E. MAIN ST., WESTMINSTER, MD. 21157</b>  |  |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>PNEUMONIA</b><br>Due to (or as a consequence of):<br>b. <b>CEREBROVASCULAR DISEASE</b><br>Due to (or as a consequence of):<br>c. <b>HYPERTENSION</b><br>Due to (or as a consequence of):<br>d.<br><br>Approximate Interval Between Onset and Death<br>a. <b>~3-4 days</b><br>b. <b>several years</b><br>c. <b>&gt;10yrs</b><br>d. |   |   |  |  |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br>   |   |   |   | 29c. License number<br><b>D 20806</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>12/12/97</b>                               |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>PATRICK A. TURNER MD 1425 LIBERTY RD ELDERSBURG MD 21784</b>   |   |   |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 15 1997</b>   |   | 32. Registrar's Signature<br>   |   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39716

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Esther Pearl Wintner

2. Date of Death  
Month Day Year

December 9, 1997

3. Time of Death

11:13am

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

165-07-2728

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

Nov 29, 1915

9. Birthplace (State or Foreign Country)

Delaware

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6121 Montrose Road

10f. Zip Code

20852

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.  
Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Information Specialist

16b. Kind of Business/Industry

National Labor  
Realtions

17. Father's Name (First, Middle, Last)

Joseph Winitner

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude Keller

19a. Informant's Name/Relationship (Type, Print)

Beatrice Pollekoff-sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10401 Grosvenor Pl. Rockville, MD 20852

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of  
cemetery, crematory or other place)

King David Mem. Gardens 12/12/97 Falls Church, VA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

 -Edward Sagel

22. Name and Address of Facility

Edward Sagel Funeral Direction  
1091 Rockville Pike Rockville MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a. Anoxic Encephalopathy

Due to (or as a consequence of):

Sequitely list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy  
performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury  
(Month, Day Year)

28b. Time of  
Injury

28c. Injury et  
Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

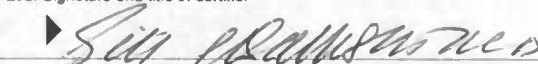
28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier  
(Check only  
one)

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D23170

29d. Date signed (Month, Day, Year)

Dec. 10, 1997

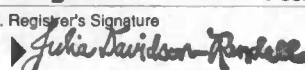
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gita Bakshi 9406 Old Georgetown Road Bethesda, MD 20814-1722

31. Date filed (Month, Day, Year)

DEC 16 1997

32. Registrar's Signature



State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39717

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM WINPISINGER

2. Date of Death

Month Day Year  
Dec 11 1997

3. Time of Death

11 30 AM

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

5. Social Security Number

300-12-8633

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Dec. 10, 1924

9. Birthplace (State or Foreign Country)

Ohio

10e. State

Maryland

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3901 Walt Ann Drive

10f. Zip Code

21042

10g. Citizen of What Country?

USA

11. Marital Status

☐ Navar Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No  
If Yes, Give Year or Dates: 1942-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)  
11

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Labor Representative

16b. Kind of Business/Industry

Labor Union

17. Father's Name (First, Middle, Last)

Joseph Henry Winpisinger

18. Mother's Name (First, Middle, Maiden Surname)

Edith Marie Knodel

19a. Informant's Name/Relationship (Type, Print)

Pearl E. Winpisinger (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3901 Walt Ann Dr., Ellicott City, MD 21042

20e. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Crematory 12-13-97

Date

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licenses

22. Name and Address of Facility

Hines-Rinaldi Funeral Home

11800 New Hampshire Ave, Silver Spring, MD 20904

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cholangio carcinoma Liver months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Acute Gastrointestinal bleeding Days

c. Upper respiratory infection Days

d. Hypertension, Diabetes M-II Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal failure, Atherosclerosis

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24e. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient

☐ ER/Outpatient

☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Suicide  
☐ Homicide ☐ Could not be determined

28e. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician

2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Pritham S. Saini MD

29c. License number

D28998

29d. Date signed (Month, Day, Year)

Dec 12 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

PRITHAM S. SAINI MD

9101 Cherry Ln # 211 Laurel MD 20708

31. Date filed (Month, Day, Year)

DEC 16 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39718

|   |   |  |  |   |   |                                 |   |  |
|---|---|--|--|---|---|---------------------------------|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>JOSEPH H. WESTON</b>   |  |  |   | 2. Date of Death<br>Month <b>December</b> Day <b>15</b> Year <b>1997</b>  |                                 | 3. Time of Death<br><b>0740 AM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>SHADY GROVE ADVENTIST HOSPITAL</b>   |  |  |   | 4b. City, Town, or Location of Death<br><b>ROCKVILLE</b>  |                                 | 4c. County of Death<br><b>MONTGOMERY</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>537-38-4955</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>55</b> Yrs.  |                                 | 8. Date of Birth (Month, Day, Year)<br><b>JULY 27, 1942</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>N. CAROLINA</b>  |  | 10a. State<br><b>MARYLAND</b>  |   | 10b. County<br><b>MONTGOMERY</b>  |                                 | 10c. City, Town or Location<br><b>SILVER SPRING</b>   |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |   | 10e. Street and Number<br><b>204 WILLIAMSBURG DR.</b>   |                                 | 10f. Zip Code<br><b>20901</b>   |  |
|   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |  |   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                              |                                 | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                               |  |
|   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |                                 | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SIGN BUILDER</b>  |  |  |   | 16b. Kind of Business/Industry<br><b>SIGN CO.</b>   |                                 |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>JOSEPH H. WESTON SR.</b>  |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>GRACE LOUISE GULLEY</b>   |                                 |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>RICHARD H. WESTON/BROTHER</b>  |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2055 ETHEL ST. #23, KELOWNA, BRITISH COLUMBIA, CANADA</b>   |                                 |   |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CHAMBERS CREMATORY</b>   |                                 | 20c. Location - City or Town, State<br><b>12/17/97 RIVERDALE, MD.</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i> MOOO91  |  |  |   | 22. Name and Address of Facility<br><b>CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD.</b>   |                                 |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Cardiac arrest</b><br>Due to (or as a consequence of):<br><b>b. Cardiomyopathy</b><br>Due to (or as a consequence of):<br><b>c. Diabetes Mellitus</b><br>Due to (or as a consequence of):<br><b>d. hypertension</b> |  |  |   | Approximate Interval Between Onset and Death<br><b>Immediate</b><br><b>4 Years</b>  |                                 |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>peripheral vascular disease</b><br><b>coronary artery disease</b>  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |                                 |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |                                 |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |                                 |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   |  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b> |   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  | 28d. Describe how injury occurred   |   |                                 |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |                                 |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |  | 29b. Signature and title of certifier<br><i>[Signature]</i> M.D.  |   |                                 |   |  |
| 29c. License number<br><b>D 45843</b>   |   |  |  | 29d. Date signed (Month, Day, Year)<br><b>December 15<sup>th</sup>, 1997</b>  |   |                                 |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SAMEH ALY 481 N. Frederick Ave. #230 Gaithersburg MD 20877</b>   |   |  |  | 31. Date filed (Month, Day, Year)<br><b>DEC 18 1997</b>   |   |                                 |   |  |
| 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |  |   |   |                                 |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]

1. [illegible]  
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WRC  
97-7187-031  
ISABEL ROBBINS  
WARD

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39719

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Isabel Robbins Ward

2. Date of Death

Month Day Year  
DEC. 13, 1997

3. Time of Death

8:00 PM.

4a. Facility Name (If not institution, give street and number)

4822 DRUMMOND AVE.

4b. City, Town, or Location of Death

CHEVY CHASE

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

215-46-1264

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 9, 1906

9. Birthplace (State or Foreign Country)

Minnesota

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Chevy Chase

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4822 Drummond Avenue

10f. Zip Code

20815

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify:  
White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Social Worker

16b. Kind of Business/Industry

Public Schools

17. Father's Name (First, Middle, Last)

Orison Benjamin Robbins

18. Mother's Name (First, Middle, Maiden Surname)

Mary Fiske

19a. Informant's Name/Relationship (Type, Print)

Maffy Forrester/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6313 Santa Maria Avenue, Las Vegas, Nevada 89108

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Montgomery Crematorium, Inc.

Date

December 17, 1997

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

M00831

*Barbara J. McMullen Lawrence*

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.  
7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a. *Hypertensive Arteriosclerotic Cardiovascular Disease*  
Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy  
performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier  
(Check only  
one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Theodore M. King*

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

DEC. 14, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

*THEODORE M. KING*

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

DEC 17 1997

32. Registrar's Signature

*John Davidson-Randall*

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 must be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39720

|   |  |  |  |  |  |  |  |  |                                   |
|---|--|--|--|--|--|--|--|--|-----------------------------------|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Dr. Caldwell S. Walker   |  |  |  | 2. Date of Death<br>Month Day Year<br>Dec. 24 97   |  | 3. Time of Death<br>7:17AM   |  |                                   |
|   | 4a. Facility Name (If not institution, give street and number)<br>Ginger Cove Health Care Center   |  |  |  | 4b. City, Town, or Location of Death<br>Annapolis  |  | 4c. County of Death<br>Anne Arundel  |  |                                   |
| Funeral<br>Director   | 5. Social Security Number<br>109-09-6810   | 6. Sex<br>M <input checked="" type="checkbox"/> F <input type="checkbox"/> | 7. Age (In yrs. last birthday)<br>86 Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>May 24 1911 |  | 9. Birthplace (State or Foreign Country)<br>South Carolina |                                   |
|   | Usual Residence of Decedent  |  |  |  |  |  |  |  |                                   |
| To Be Completed by Funeral Director   | 10a. State<br>MD   |  | 10b. County<br>Anne Arundel  |  | 10c. City, Town or Location<br>Annapolis   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |                                   |
|   | 10e. Street and Number<br>3211 River Crescent Drive  |  |  |  | 10f. Zip Code<br>21401   |  | 10g. Citizen of What Country?<br>United States   |  |                                   |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WWII |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                               |  |                                   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5  |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Dentist   |  | 16b. Kind of Business/Industry<br>Dentistry  |  |                                   |
|   | 17. Father's Name (First, Middle, Last)<br>Paul N. Walker  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Temperance Carraway   |  |  |  |                                   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Eleanor G. Walker (Wife)   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3211 River Crescent Drive Annapolis, MD 21401   |  |  |  |                                   |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Ft. Lincoln Crematory Dec. 6 1997 Brentwood, Maryland                            |  | Date   |  | 20c. Location - City or Town, State  |  |                                   |
|   | 21. Signature of Funeral Service Licensee<br><i>Donald S. Taylor</i>   |  |  |  | 22. Name and Address of Facility<br>John M. Taylor Funeral Home, Inc.<br>147 Duke of Gloucester St. Annapolis, MD 21401  |  |  |  |                                   |
|   | 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Metastatic Adenocarcinoma - ? primary 1 month?<br>b. Possible CAUSE of prostate 4 years<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |  |  |  |  |  |                                   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Diabetes, Hypertension   |  |  |  |  |  |  |  |                                   |
| Physician<br>/Medical<br>Examiner   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |  |  |  |  |  |  |                                   |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |                                   |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |  |  |  |  |                                   |
|   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)  |  |  |  |  |  |  |  |                                   |
|   | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicida 4 <input type="checkbox"/> Homicida   |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No           |  | 28d. Describe how Injury occurred |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |  |  |                                   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |  |  |  |  |  |  |                                   |
| 29b. Signature and title of certifier.<br><i>N. B...</i>  |  |  |  | 29c. License number<br>J00561  |  | 29d. Date signed (Month, Day, Year)<br>12/4/97     |  |  |                                   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Robert O. Biern, M.D. 900 Bestgate Road Annapolis, Maryland 21401   |  |  |  |  |  |  |  |  |                                   |
| 31. Date filed (Month, Day, Year)<br>DEC 10 1997  |  | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>                 |  |  |  |  |  |  |                                   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director


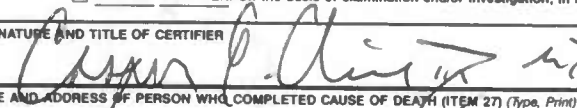

Medical Certification: To Be Completed by Physician/Medical Examiner



97 39721

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Marianna N WHITE</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>12</b> DAY <b>15</b> YEAR <b>97</b>  |  | 3. TIME OF DEATH<br><b>11:20 a m</b>                                       |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-36-5349</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>92</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>June 12 1905</b>                 |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Kentucky</b>   |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Homewood</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>                    |  |
| 9c. COUNTY OF DEATH<br><b>Frederick</b>   |  |   |  | 10a. STATE<br><b>Maryland</b>   |  |  |  |
| 10b. COUNTY<br><b>Washington</b>  |  |   |  | 10c. CITY, TOWN OR LOCATION<br><b>Williamsport</b>  |  |  |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  | 10e. STREET AND NUMBER<br><b>16505 Virginia Avenue</b>  |  |  |  |
| 10f. ZIP CODE<br><b>21795</b>   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b> |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>2</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Teacher</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>School for Deaf</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Anderson R. Nunnelley</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Anna A. Taylor</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>William A. White - Son</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8229 Peters Road Frederick, Maryland 21704</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Rose Hill Cemetery 12-17-97</b>   |  | 20c. LOCATION — City or Town, State<br><b>Hagerstown, Maryland</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Minnich Funeral Home<br/>415 E. Wilson Blvd. Hagerstown, Md. 21740</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cancer of Urinary Bladder</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>a. _____<br>b. _____<br>c. _____<br>d. _____<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  |  | Approximate Interval Between Onset and Death<br><b>years</b>   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>_____<br>_____  |  |   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide |  |   |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |   |  | 29c. LICENSE NUMBER<br><b>D16428</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>12/15/97</b>                     |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 18 1997</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39722

|   |   |   |   |  |  |   |  |  |   |   |  |  |             |    |    |  |  |                                       |  |   |  |   |  |                                   |  |   |  |  |  |  |  |                                      |  |  |  |
|---|---|---|---|--|--|---|--|--|---|---|--|--|-------------|----|----|--|--|---------------------------------------|--|---|--|---|--|-----------------------------------|--|---|--|--|--|--|--|--------------------------------------|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>FRANCIS Wheeler JR.</b>  |   |   |  | 2. Date of Death<br>Month <b>Dec</b> Day <b>18</b> Year <b>1997</b>  |   | 3. Time of Death<br><b>8:35 a.m.</b>   |  |   |   |  |  |             |    |    |  |  |                                       |  |   |  |   |  |                                   |  |   |  |  |  |  |  |                                      |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Southern Maryland Hospital</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>Clinton</b>   |   | 4c. County of Death<br><b>Prince George's</b>  |  |   |   |  |  |             |    |    |  |  |                                       |  |   |  |   |  |                                   |  |   |  |  |  |  |  |                                      |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-32-7685</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>63</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>JULY 6, 1934</b>                                     |  |   |   |  |  |             |    |    |  |  |                                       |  |   |  |   |  |                                   |  |   |  |  |  |  |  |                                      |  |  |  |
|   | 10a. State<br><b>MARYLAND</b>   |   | 10b. County<br><b>PRINCE GEORGE</b>   |  | 10c. City, Town or Location<br><b>FORESTVILLE</b>  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |   |  |  |             |    |    |  |  |                                       |  |   |  |   |  |                                   |  |   |  |  |  |  |  |                                      |  |  |  |
| To Be Completed by Funeral Director   | 10e. Street and Number<br><b>1301 WOODLARK DRIVE</b>  |   |   |  | 10f. Zip Code<br><b>20747</b>  |   | 10g. Citizen of What Country?<br><b>UNITED STATES</b>  |  |   |   |  |  |             |    |    |  |  |                                       |  |   |  |   |  |                                   |  |   |  |  |  |  |  |                                      |  |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                        |  |   |   |  |  |             |    |    |  |  |                                       |  |   |  |   |  |                                   |  |   |  |  |  |  |  |                                      |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>8TH GRADE</b>  |   | College (1-4 or 5+)<br><b>RETIRED WAREHOUSE INSPECTOR</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  |   | 16b. Kind of Business/Industry<br><b>GOVERNMENT</b>  |  |   |   |  |  |             |    |    |  |  |                                       |  |   |  |   |  |                                   |  |   |  |  |  |  |  |                                      |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>FRANK M. WHEELER</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARY MARTHA SMALLWOOD WHEELER</b>  |   |  |  |   |   |  |  |             |    |    |  |  |                                       |  |   |  |   |  |                                   |  |   |  |  |  |  |  |                                      |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>DOROTHY A. WHEELER / WIFE</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1301 WOODLARK DRIVE, FORESTVILLE, MARYLAND 20747</b>                                     |   |  |  |   |   |  |  |             |    |    |  |  |                                       |  |   |  |   |  |                                   |  |   |  |  |  |  |  |                                      |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>SACRED HEART CHURCH CEM.</b>   |  | Date<br><b>12/22/97</b>  |   | 20c. Location - City or Town, State<br><b>LA PLATA, MARYLAND</b>                               |  |   |   |  |  |             |    |    |  |  |                                       |  |   |  |   |  |                                   |  |   |  |  |  |  |  |                                      |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Lidia C. Thornton Johnson</b><br><b>LIDIA C. THORNTON JOHNSON M00583</b>  |   |   |  | 22. Name and Address of Facility<br><b>THORNTON FUNERAL HOME, P.A.</b><br><b>3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640</b>   |   |  |  |   |   |  |  |             |    |    |  |  |                                       |  |   |  |   |  |                                   |  |   |  |  |  |  |  |                                      |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |  |  |   |  |  |   |   |  |  |             |    |    |  |  |                                       |  |   |  |   |  |                                   |  |   |  |  |  |  |  |                                      |  |  |  |
|   | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>metastatic lung cancer</b></td> <td rowspan="4">Approximate Interval Between Onset and Death<br/><b>years</b></td> </tr> <tr> <td>b. <b>Respiratory failure</b></td> <td rowspan="3"><b>days</b></td> </tr> <tr> <td>c.</td> </tr> <tr> <td>d.</td> </tr> </table> |   |   |  |  |   |  |  | Immediate Cause (Final disease or condition resulting in death) | a. <b>metastatic lung cancer</b>  | Approximate Interval Between Onset and Death<br><b>years</b> | b. <b>Respiratory failure</b>  | <b>days</b> | c. | d. |  |  |                                       |  |   |  |   |  |                                   |  |   |  |  |  |  |  |                                      |  |  |  |
|   | Immediate Cause (Final disease or condition resulting in death)   | a. <b>metastatic lung cancer</b>  | Approximate Interval Between Onset and Death<br><b>years</b>  |  |  |   |  |  |   |   |  |  |             |    |    |  |  |                                       |  |   |  |   |  |                                   |  |   |  |  |  |  |  |                                      |  |  |  |
| b. <b>Respiratory failure</b>   |   | <b>days</b>   |   |  |  |   |  |  |   |   |  |  |             |    |    |  |  |                                       |  |   |  |   |  |                                   |  |   |  |  |  |  |  |                                      |  |  |  |
| c.  |   |   |   |  |  |   |  |  |   |   |  |  |             |    |    |  |  |                                       |  |   |  |   |  |                                   |  |   |  |  |  |  |  |                                      |  |  |  |
| d.  |   |   |   |  |  |   |  |  |   |   |  |  |             |    |    |  |  |                                       |  |   |  |   |  |                                   |  |   |  |  |  |  |  |                                      |  |  |  |
| <table border="1"> <tr> <td colspan="4">Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</td> <td colspan="4">23b. Did tobacco use contribute to the cause of death?<br/><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown</td> </tr> <tr> <td colspan="4"></td> <td colspan="2">24a. Was an autopsy performed?<br/><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> <td colspan="2">24b. Were autopsy findings available prior to completion of cause of death?<br/><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table>  |   |   |   |  |  |   |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |             |    |    |  |  |                                       |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |                                   |  |   |  |  |  |  |  |                                      |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |  |  |   |   |  |  |             |    |    |  |  |                                       |  |   |  |   |  |                                   |  |   |  |  |  |  |  |                                      |  |  |  |
|   |   |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |   |   |  |  |             |    |    |  |  |                                       |  |   |  |   |  |                                   |  |   |  |  |  |  |  |                                      |  |  |  |
| <table border="1"> <tr> <td colspan="2">25. Was case referred to medical examiner?<br/><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> <td colspan="6">28. Place of Death (Check only one)<br/>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)</td> </tr> <tr> <td colspan="2">27. Manner of Death<br/><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br/><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined</td> <td colspan="2">28a. Date of Injury (Month, Day Year)</td> <td colspan="2">28b. Time of Injury<br/><b>M</b></td> <td colspan="2">28c. Injury at Work?<br/><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td colspan="2">28d. Describe how Injury occurred</td> </tr> <tr> <td colspan="4">29a. Certifier (Check only one)<br/><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</td> <td colspan="2">29b. Signature and title of certifier<br/><b>Bahram Redjaee</b></td> <td colspan="2">29c. License number<br/><b>D39691</b></td> <td colspan="2">29d. Date signed (Month, Day, Year)<br/><b>12/18/97</b></td> </tr> </table> |   |   |   |  |  |   |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No      |   | 28. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |             |    |    | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year) |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28d. Describe how Injury occurred |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |  | 29b. Signature and title of certifier<br><b>Bahram Redjaee</b> |  | 29c. License number<br><b>D39691</b> |  | 29d. Date signed (Month, Day, Year)<br><b>12/18/97</b> |  |
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| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28d. Describe how Injury occurred  |   |   |  |  |             |    |    |  |  |                                       |  |   |  |   |  |                                   |  |   |  |  |  |  |  |                                      |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |   |   | 29b. Signature and title of certifier<br><b>Bahram Redjaee</b>   |  | 29c. License number<br><b>D39691</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>12/18/97</b>   |   |   |  |  |             |    |    |  |  |                                       |  |   |  |   |  |                                   |  |   |  |  |  |  |  |                                      |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>BAHRAM REDJAE U067 old BRANCH AVE TEMPLE HILLS MD</b>  |   |   |   |  |  |   |  |  |   |   |  |  |             |    |    |  |  |                                       |  |   |  |   |  |                                   |  |   |  |  |  |  |  |                                      |  |  |  |
| <table border="1"> <tr> <td colspan="4">31. Date filed (Month, Day, Year)<br/><b>DEC 22 1997</b></td> <td colspan="4">32. Registrar's Signature<br/><b>Lidia Thornton Johnson</b></td> </tr> </table>   |   |   |   |  |  |   |  | 31. Date filed (Month, Day, Year)<br><b>DEC 22 1997</b>  |   |   |  | 32. Registrar's Signature<br><b>Lidia Thornton Johnson</b>   |             |    |    |  |  |                                       |  |   |  |   |  |                                   |  |   |  |  |  |  |  |                                      |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 22 1997</b>   |   |   |   | 32. Registrar's Signature<br><b>Lidia Thornton Johnson</b>   |  |   |  |  |   |   |  |  |             |    |    |  |  |                                       |  |   |  |   |  |                                   |  |   |  |  |  |  |  |                                      |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 39723**  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JERALD WEAVER

2. Date of Death

Month Day Year  
DECEMBER 15, 1997

3. Time of Death

8:55 am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

4311 23rd PARKWAY APT. 112

4b. City, Town, or Location of Death

TEMPLE HILLS

4c. County of Death

P.G. COUNTY

5. Social Security Number

579-58-5504

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

53 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
FEB. 29, 1944

9. Birthplace (State or Foreign Country)

WASHINGTON DC

Usual Residence of Decedent

10a. State

MD

10b. County

P.G. COUNTY

10c. City, Town or Location

TEMPLE HILLS

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

4311 23rd PARKWAY APT. 112

10f. Zip Code

20748

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HEATING EQUIP. MECH

16b. Kind of Business/Industry

PRIVATE

17. Father's Name (First, Middle, Last)

HAROLD WEAVER

18. Mother's Name (First, Middle, Maiden Surname)

MILTONETTE RIVERS

19a. Informant's Name/Relationship (Type, Print)

BARBARA WEAVER/ WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4311 23rd PARKWAY APT 112 TEMPLE HILLS MD 20748

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

HARMONY MEMORIAL PARK

Date

12-19-97

20c. Location - City or Town, State

LANDOVER MD

21. Signature of Funeral Service Licensee

Alex S. Pope R

22. Name and Address of Facility

ALEXANDER S. POPE FUNERAL HOME  
2617 PENN. AVE S.E WASHINGTON DC 2002023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. ARDS  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb.   
Due to (or as a consequence of):c.   
Due to (or as a consequence of):d.   
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

5 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Frank M. Ryan MD

29c. License number

D19431

29d. Date signed (Month, Day, Year)

12/18/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frank M. Ryan MD 11701 Livingston Rd # 203 Ft. Wash MD 20744

31. Date filed (Month, Day, Year)

DEC 19 1997

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 39724

Amended #5 per FH G755 1/8/98 EW

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES FELTON WILLIAMS, SR.

2. Date of Death

Month Day Year  
DECEMBER 13, 1997

3. Time of Death

4:10 PM

Funeral  
Director

4e. Facility Name (If not institution, give street and number)

PRINCE GEORGE'S HOSPITAL CENTER

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

PRINCE GEORGE'S

5. Social Security Number

578-54-1807  
~~587-54-1807~~

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

56

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
MARCH 2, 1941

9. Birthplace (State or Foreign Country)

NORTH CAROLINA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

PRINCE GEORGE'S

10c. City, Town or Location

CAPITOL HEIGHTS

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6502 RONALD RD. #103

10f. Zip Code

20743

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

10

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CAB DRIVER

16b. Kind of Business/Industry

PRIVATE

17. Father's Name (First, Middle, Last)

PETE MARSHALL WILLIAMS

18. Mother's Name (First, Middle, Maiden Surname)

ANNA LEE FREEMAN

19a. Informant's Name/Relationship (Type, Print)

FRANCES WILLIAMS/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6502 RONALD RD. #103 CAPITOL HEIGHTS, MD. 20743

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METROPOLITAN CREMATORY

Date

12/18/97

20c. Location - City or Town, State

ALEXANDRIA, VA.

21. Signature of Funeral Service Licensee

Keith A. Savage 11/085

22. Name and Address of Facility

ALEXANDER S. POPE FUNERAL HOMES

5538 MARLBORO PIKE/FORESTVILLE, MARYLAND 20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardio Pulmonary Arrest

Due to (or as a consequence of):

b. Cardiac Asystole

Due to (or as a consequence of):

c. Coronary Artery disease.

Due to (or as a consequence of):

d. Diabetes Mellitus

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End stage Kidney disease  
Hemodialysis. Retinopathy  
Peripheral Vascular disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D17989

29d. Date signed (Month, Day, Year)

12-14-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

R. SUPAL SINGH 7525 Greenway Center GreenBELT. Md. 20770  
GREENWAY CENTER DRIVE

31. Date filed (Month, Day, Year)

DEC 19 1997

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 39725

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

|   |  |  |                                |  |  |
|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><u>Dollie Williams</u>  |  | 2. Date of Death<br>Month <u>December</u> Day <u>12</u> Year <u>1997</u>   |                                | 3. Time of Death<br><u>3:10 AM</u>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><u>4918 Heath St</u>  |  | 4b. City, Town, or Location of Death<br><u>Capitol Heights P.D. only</u>   |                                | 4c. County of Death<br><u>P.D. only</u>  |  |
| 5. Social Security Number<br><u>246-38-4834</u>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><u>75</u> Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><u>APRIL 23, 1922</u> |
| 9. Birthplace (State or Foreign Country)<br><u>NASH COUNTY, N.C.</u>  |  |  |                                |  |  |
| Usual Residence of Decedent   |  | 10a. State<br><u>MD.</u>   |                                |  |  |
| 10b. County<br><u>PRINCE GEORGE'S</u>   |  | 10c. City, Town or Location<br><u>CAPITOL HEIGHTS</u>  |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><u>4918 HEATH STREET</u>  |  | 10f. Zip Code<br><u>20743</u>  |                                | 10g. Citizen of What Country?<br><u>USA</u>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <u>BLACK</u>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u></u>   |                                |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>TELEMETRY TECHNICIAN</u>  |  | 16b. Kind of Business/Industry<br><u>MEDICAL</u>   |                                |  |  |
| 17. Father's Name (First, Middle, Last)<br><u>THADDUS HARRISON</u>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>JENNIE PLUMMER</u>   |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>BERNADETTE WILLIAMS</u>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>4918 HEATH STREET CAPITOL HGTS., MARYLAND 20743</u>  |                                |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>CEDAR HILL CEMETERY</u>   |                                | 20c. Location - City or Town, State<br><u>12/15/97 SUITLAND, MARYLAND</u>  |  |
| 21. Signature of Funeral Service Licensee<br><u>[Signature]</u>   |  | 22. Name and Address of Facility<br><u>ALEXANDER S. POPE FUNERAL HOME</u><br><u>5538 MARLBORO PIKE FORESTVILLE, MARYLAND 20743</u>   |                                |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |                                |  |  |
| Immediate Cause (Final disease or condition resulting in death)   |  | a. <u>CARDIO PULMONARY ARREST</u>  |                                | Due to (or as a consequence of):   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  | b. <u>SEPTIC SHOCK</u>   |                                | Due to (or as a consequence of):   |  |
|   |  | c. <u>STAGE FOUR COLON CANCER</u>  |                                | Due to (or as a consequence of):   |  |
|   |  | d. <u></u>   |                                | Due to (or as a consequence of):   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |                                |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |                                |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |                                |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)   |                                | 28b. Time of Injury<br>M   |  |
|   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |                                | 28d. Describe how injury occurred  |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |                                |  |  |
| 29b. Signature and title of certifier<br><u>[Signature]</u>   |  | 29c. License number<br><u>D 31089</u>  |                                | 29d. Date signed (Month, Day, Year)<br><u>12/12/97</u>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>Dr. Bone 9201 Suite F M.L. King Ave</u>  |  |  |                                |  |  |
| 31. Date filed (Month, Day, Year)<br><u>DEC 15 1997</u>   |  | 32. Registrar's Signature<br><u>[Signature]</u>  |                                |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39726

|   |   |   |  |  |   |  |  |   |
|---|---|---|--|--|---|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Roy B. Wright</b>                                    |   |  |  | 2. Date of Death<br>Month <b>December</b> Day <b>6</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>1:40 AM</b>   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Medlantic Manor at Layhill</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>  |  | 4c. County of Death<br><b>Montgomery</b>   |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>579-05-3125</b>   |   | 8. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.   | If Under 1 Year<br>Months <b>0</b> Days <b>0</b>  | If Under 24 Hrs.<br>Hours <b>0</b> Min. <b>0</b>   | 8. Date of Birth (Month, Day, Year)<br><b>April 4, 1913</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>South Carolina</b>   |
|   | Usual Residence of Decedent   |   |  |  |   |  |  |   |
| 10a. State<br><b>MD</b>   |   | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Silver Spring</b>  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
| 10e. Street and Number<br><b>2601 Bel Pre Rd.</b>   |   |   |  | 10f. Zip Code<br><b>20906</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |   |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b> College (1-4or 5+)  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Construction Worker</b>  |   | 16b. Kind of Business/Industry<br><b>D.C. Transit</b>  |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Isaac Wright</b>  |   |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Laura Boykin</b>  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Vistula A. McCallum - Niece</b>  |   |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1353 Tuckerman Street N W Washington DC 20011</b> |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Washington National Cem</b>  |  | 20c. Location - City or Town, State<br><b>12-11 Suitland, MD</b>   |   |  |  |   |
| 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br><b>Marshall's Funeral Home, Inc.<br/>4217 9th Street N W Washington DC 20011</b>   |   |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. METASTATIC CARCINOMA</b><br>Due to (or as a consequence of):<br><b>b. ADENOCARCINOMA PROSTATE</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |   |   |  |  |   |  |  | Approximate Interval Between Onset and Death<br><b>6 months</b>   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |
|   |   |   |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D15405</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>December 12, 1997</b>  |  |   |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br><b>Cesar A. Lopez, M.D. 18111 Prince Philip Drive, Olney, MD 20832</b>  |   |   |  |  |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>DEC 16 1997</b>   |   | 32. Registrar's Signature<br>  |  |  |   |  |  |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39727

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Kenneth B. Winston

2. Date of Death  
Month Day Year

Dec. 10, 1997

3. Time of Death

11:15 AM

4a. Facility Name (If not institution, give street and number)

Prince Georges Hospital

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince Georges

5. Social Security Number

227-58-4294

6. Sex

M 20 F

7. Age (In yrs. last birthday)

52

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Nov. 20, 1945

9. Birthplace (State or Foreign Country)

Chesterfield, VA

Usual Residence of Decedent

10a. State

Maryland

10b. County

10c. City, Town or Location

Largo

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

814 New Orchard Place,

10f. Zip Code

20772

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

High School

Collage (1-4 or 5+)

4 Years College

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic Relations

16b. Kind of Business/Industry

District Court

17. Father's Name (First, Middle, Last)

James D. Winston

18. Mother's Name (First, Middle, Maiden Summa)

Edna Finn

19a. Informant's Name/Relationship (Type, Print)

Sheryl Bailey (sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

814 New Orchard Place Largo, Maryland 20772

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Park

Date

Dec. 16, 97

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Latney's Funeral Home, Inc.

3831 Georgia Ave, NW Wash, DC 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *AIDS*  
Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *renal failure*  
Dua to (or as a consequence of):

c.   
Dua to (or as a consequence of):

d.   
Dua to (or as a consequence of):

Approximate interval Between Onset and Death

*YRS  
days.*

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☐ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

*[Signature]*

29c. License number

041978

29d. Date signed (Month, Day, Year)

12-12-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nader Dayerkhan

Part. Chervy MD 20785

31. Date filed (Month, Day, Year)

DEC 17 1997

32. Registrar's Signature

*[Signature]*

State Registrar

Baltimore, Maryland 21215-0020

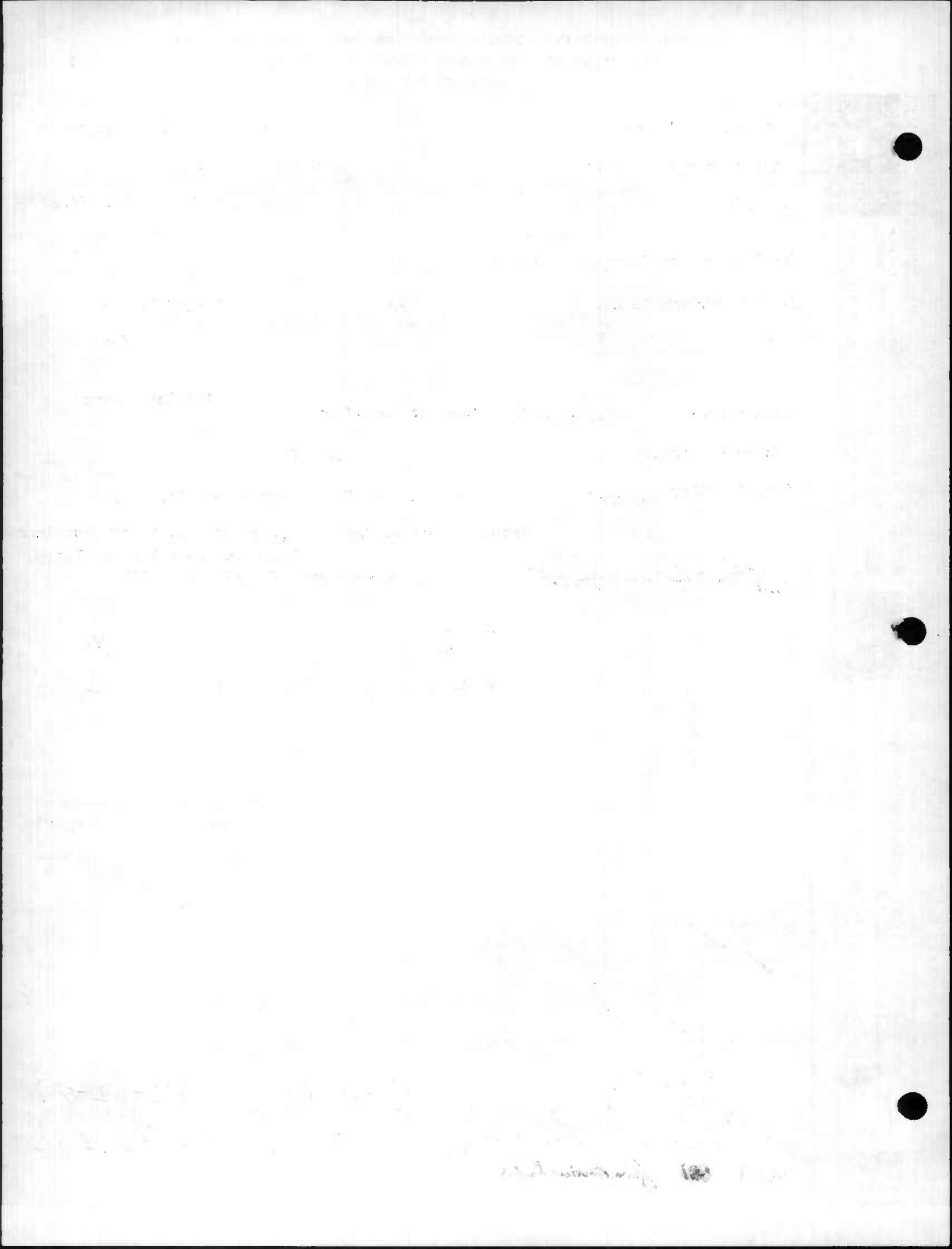
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39728

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Emily Marie Watson

2. Date of Death

Month

Day

Year

12

10

1997

3. Time of Death

4:30 AM

4a. Facility Name (If not institution, give street and number)

Calvert Manor Nursing Home

4b. City, Town, or Location of Death

Rising Sun

4c. County of Death

Cecil

Funeral  
Director

5. Social Security Number

215-09-5019

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

08/23/1912

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Havre de Grace

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1227 Ontario Street

10f. Zip Code

21078

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Charles Nelson Barnard

18. Mother's Name (First, Middle, Maiden Surname)

Eva Brown

19a. Informant's Name/Relationship (Type, Print)

Capt. Frederick W. Berg- Son 599 Chapel Terr. Havre de Grace, MD 21078

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Angel Hill Cemetery

Date

12/13/1997

20c. Location - City or Town, State

Havre de Grace, MD

21. Signature of Funeral Service Licensee

George M. Hampton Jr.

22. Name and Address of Facility

Mitchell-Smith Funeral Home, P.A.

123 S. Washington St. Havre de Grace, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lobar Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 days

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

A.S.C.H.D.

Alzheimer's Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Neil R. Taylor Jr.

29c. License number

0-11115

29d. Date signed (Month, Day, Year)

12-10-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Neil R. Taylor Jr. MD Calvert Healthcare Rising Sun MD 21911

31. Date filed (Month, Day, Year)

DEC 12 1997

32. Registrar's Signature

John Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James McKinley Werking

2. Date of Death  
Month Day Year

December 9, 1997

3. Time of Death

8:00 P.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Williamsport Nursing Home

4b. City, Town, or Location of Death

Williamsport

4c. County of Death

Washington

5. Social Security Number

220-18-1013

8. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

91

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 4, 1906

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

521 Maryland Avenue

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Operator at Sewer Plant

16b. Kind of Business/Industry

City Of Hagerstown

17. Father's Name (First, Middle, Last)

Charlton F. Werking

18. Mother's Name (First, Middle, Maiden Surname)

Mary Smith

19a. Informant's Name/Relationship (Type, Print)

John A. Werking

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17321 Amber Drive Hagerstown, Maryland 21740

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rest Haven Cemetery

Date

12/12/97

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gerald N. Minnich 305 N. Potomac Street

Funeral Home Hagerstown, Maryland 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Renal Carcinoma

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

26. Place of Death (Check only one)

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D33700

29d. Date signed (Month, Day, Year)

DECEMBER 10, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ted E. Howe, M.D. 7542 Overlook Dr. Boonsboro, Maryland 21713

31. Date filed (Month, Day, Year)

DEC 11 1997

32. Registrar's Signature

State  
RegistrarBaltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39730

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Alvin Davis Yeakle

2. Date of Death

Dec. 10, 1997

3. Time of Death

6:45 A.M.

4a. Facility Name (If not institution, give street and number)

Avalon Manor Nursing Home

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

214-09-7477

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Apr. 21, 1908

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Washington

10c. City, Town or Location

Maugansville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13044 Village Mill Dr.

10f. Zip Code

21767

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Salesman

16b. Kind of Business/Industry

Retail

17. Father's Name (First, Middle, Last)

George Cleveland Yeakle

18. Mother's Name (First, Middle, Maiden Surname)

Anne Maude Foreman

19a. Informant's Name/Relationship (Type, Print)

Ruth A. Yeakle (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14014 Marsh Pike Hagerstown, Md. 21742

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Smithsburg Crematory Dec. 11, 1997

Date

20c. Location - City or Town, State

Smithsburg, Md.

21. Signature of Funeral Service Licensee

Dennis L. Davis

22. Name and Address of Facility

Davis Funeral Home 12525 Bradbury Ave.  
Smithsburg, Md. 2178323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1 min

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Chronic obstructive Pulmonary Disease

Due to (or as a consequence of):

2 hr

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anteroseptal myocardial infarction chronic  
myocardial ischemic disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
2 ☐ Accident 6 ☐ Could not be  
3 ☐ Suicide 6 ☐ determined  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Dennis L. Davis

29c. License number

D18019

29d. Date signed (Month, Day, Year)

Dec 10, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vasant Datta 334 Mill St. Hagerstown, Md. 21740

31. Date filed (Month, Day, Year)

DEC 15 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 39731**  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) **Rose P. Zamanski** 2. Date of Death  
Month **December** Day **14**, Year **1997** 3. Time of Death  
**8:53 PM**

Funeral  
Director

4a. Facility Name (If not institution, give street and number) **Shady Grove Adventist Hospital** 4b. City, Town, or Location of Death **Rockville** 4c. County of Death **Montgomery**

5. Social Security Number **213-74-5782** 6. Sex ☐ M ☒ F 7. Age (In yrs. last birthday) **90** Yrs. If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) **January 19, 1907** 9. Birthplace (State or Foreign Country) **Maryland**

Usual Residence of Decedent 10a. State **Maryland** 10b. County **Montgomery** 10c. City, Town or Location **Brookeville** 10d. Inside City Limits ☐ Yes ☒ No

10e. Street and Number **18608 Queen Elizabeth Drive** 10f. Zip Code **20833** 10g. Citizen of What Country? **United States**

11. Marital Status ☐ Never Married ☐ Married ☒ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: **White**

15. Decedent's Education (Specify only highest grade completed) **Elementary/Secondary (0-12)** **12** **College (1-4 or 5+)** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Homemaker** 16b. Kind of Business/Industry **Own Home**

17. Father's Name (First, Middle, Last) **Julius Pross** 18. Mother's Name (First, Middle, Maiden Surname) **Bertha Koch**

19a. Informant's Name/Relationship (Type, Print) **Joan Z. Parr (daughter)** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **18608 Queen Elizabeth Drive, Brookeville, MD 20833**

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) **Lulaney Valley Memorial Gardens** **12-18-97** **Timonium, Maryland** 20c. Location - City or Town, State

21. Signature of Funeral Service Licensee **Carol A. Selman** 22. Name and Address of Facility **Rapp Funeral Services, P.A.** **933 Gist Avenue, Silver Spring, Maryland 20910**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **RESPIRATORY FAILURE** **PULMONARY EMPHYSEMA** **96 HOURS** **5 YEARS** **Approximate Interval Between Onset and Death**

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☒ No

25. Was case referred to medical examiner? ☐ Yes ☒ No 26. Place of Death (Check only one) ☒ Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA ☐ Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Pending investigation ☐ Accident ☐ Suicide ☐ Homicide ☐ Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury **M** 28c. Injury at Work? ☐ Yes ☒ No 28d. Describe how injury occurred 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier **Thomas E. Dawley MD** 29c. License number **016458** 29d. Date signed (Month, Day, Year) **DEC 15, 1997**

30. Name and address of person who completed cause of death (Item 28a) (Type, Print) **Thomas E. Dawley, MD 17904 GEORGIA AVE. O'DONAY MARYLAND 20832**

31. Date filed (Month, Day, Year) **DEC 16 1997** 32. Registrar's Signature **John Davidson-Randall**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

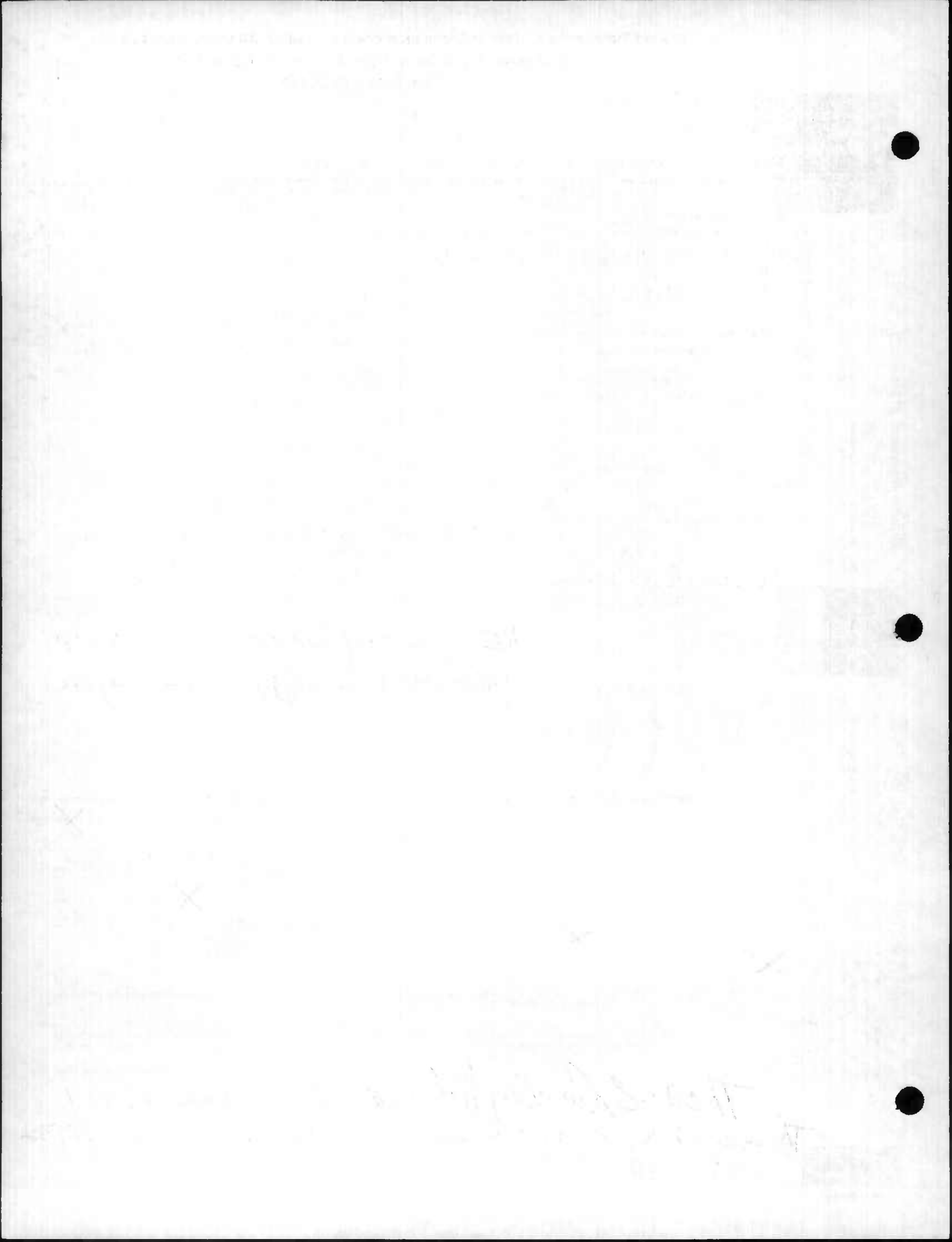
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39732

|   |   |  |  |  |  |   |   |   |   |  |
|---|---|--|--|--|--|---|---|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Charles Cecil Zimmerman</b>  |  |  |  |  | 2. Date of Death<br>Month <b>December</b> Day <b>3</b> , Year <b>1997</b>   |   | 3. Time of Death<br><b>6:15 pm</b>                                      |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Anne Arundel Medical Center</b>  |  |  |  |  | 4b. City, Town, or Location of Death<br><b>Annapolis</b>  |   | 4c. County of Death<br><b>Anne Arundel</b>                              |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>448-20-3766</b>   |  | 6. Sex<br><b>1</b> M <b>2</b> F  |  | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>Aug 17, 1926</b>    |   | 9. Birthplace (State or Foreign Country)<br><b>Oklahoma</b> |  |
|   | Usual Residence of Decedent   |  |  |  |  |   |   |   |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Anne Arundel</b>   |  | 10c. City, Town or Location<br><b>Annapolis</b>  |   |   |   | 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No         |  |
|   | 10e. Street and Number<br><b>1118 NSkyway Drive</b>   |  |  |  | 10f. Zip Code<br><b>21401</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>                   |   |   |  |
|   | 11. Marital Status<br><b>1</b> Navar Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+)  |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Upholsterer</b>                    |   |   | 16b. Kind of Business/Industry<br><b>Furniture Upholstery</b>           |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Emil Zimmerman</b>  |  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rea</b>   |   |   |   |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Janis Zimmerman/wife</b>   |  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1118 N. Skyway Drive, Annapolis, MD 21401</b> |   |   |   |  |
|   | 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MD Veterans Cemetery</b>  |  | Data<br><b>Dec. 8 1997</b>   |   | 20c. Location - City or Town, State<br><b>Crownsville, MD</b> |   |   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>James E. Barranco</i>   |  |  |  |  | 22. Name and Address of Facility<br><b>Barranco &amp; Sons, P.A. Severna Park Funeral Home<br/>495 Gov. Ritchie Hwy., Severna Park, MD 21146</b>  |   |   |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Respiratory Failure</b><br>Due to (or as a consequence of):<br>b. <b>Sleep apnea</b><br>Due to (or as a consequence of):<br>c. <b>Coronary artery disease</b><br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause: enter underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |  |  |   |   |   |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |   |   |   |   |  |
| To Be Completed by Physician/Medical Examiner   | 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown   |  |  |  |  |   |   |   |   |  |
|   | 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No  |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No   |   |   |   |  |
|   | 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No  |  | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |  |  |   |   |   |   |  |
|   | 27. Manner of Death<br><b>1</b> Natural <b>5</b> Pending Investigation<br><b>2</b> Accidental <b>6</b> Could not be determined<br><b>3</b> Suicidal <b>4</b> Homicidal  |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No              |   | 28d. Describe how injury occurred                           |  |
|   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |   |   |   |  |
| 29a. Certifier (Check only one)<br><b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |  |  |  |   |   |   |   |  |
| 29b. Signature and title of certifier<br><i>Robert T. Peterson MD</i>   |   |  |  |  | 29c. License number<br><b>024804</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>12-4-97</b>         |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Robert. T. Peterson, M.D., 600 Ridgeley Ave., Suite 121, Annapolis, MD 21401</b>   |   |  |  |  |  |   |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 11 1997</b>   |   |  |  |  | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>   |   |   |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39733

|   |  |  |   |  |  |  |   |  |                                   |
|---|--|--|---|--|--|--|---|--|-----------------------------------|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>CORA MARIE ZELLO</b>  |  |   |  | 2. Date of Death<br>Month <b>December</b> Day <b>11</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>12:45 P.M.</b>   |  |                                   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Williamsport Nursing Home</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Williamsport</b>  |  | 4c. County of Death<br><b>Washington</b>  |  |                                   |
| Funeral<br>Director                           | 5. Social Security Number<br><b>218-34-3611</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>May 30, 1918</b>                                  |  |                                   |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Washington</b>   |  | 10c. City, Town or Location<br><b>Hagerstown</b>  |  |                                   |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>12307 Walnut Point West</b>  |  | 10f. Zip Code<br><b>21740</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |                                   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |                                   |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |   |  |                                   |
|   | 17. Father's Name (First, Middle, Last)<br><b>William O. Miles</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Cora S. Hull</b>   |  |   |  |                                   |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Angelo Zello, Husband</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12307 Walnut Point West, Hagerstown, Maryland 21740</b>                                  |  |   |  |                                   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. Paul's Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>Dec. 15 Clear Spring, Maryland</b>   |  | 20d. Date   |  |                                   |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Douglas A. Fiery Funeral Home</b><br><b>1331 Eastern Blvd. N., Hagerstown, Maryland 21742</b>  |  |  |  |   |  |                                   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>a. <b>ASPIRATION PNEUMONIA</b><br/>Due to (or as a consequence of):</p> <p>b. <b>DYSPHAGIA</b><br/>Due to (or as a consequence of):</p> <p>c. <b>CEREBRAL INFARCT</b><br/>Due to (or as a consequence of):</p> <p>d. _____</p> </div> <div style="width: 35%; text-align: center;"> <p><b>24 Hours</b></p> <p><b>3 MONTHS</b></p> </div> </div> |  |   |  |  |  |   |  |                                   |
| To Be Completed by Physician/Medical Examiner | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |   | 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |                                   |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |                                   |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |                                   |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner  |  | 29b. Signature and title of certifier<br>   |  |  |  |   |  |                                   |
|   | 29c. License number<br><b>D33700</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>December 12, 1997</b>   |  |  |  |   |  |                                   |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Ted E. Howe M.D. 7542 Overlook Dr. Boonsboro, Maryland 21713</b>  |  |   |  |  |  |   |  |                                   |
|   | 31. Date filed (Month, Day, Year)<br><b>DEC 15 1997</b>  |  | 32. Registrar's Signature<br>   |  |  |  |   |  |                                   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

37 39734

## Certificate of Death

Reg. No.

|   |  |  |   |  |   |  |  |  |
|---|--|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><i>Phillip Armstrong</i>   |  |   |  | 2. Date of Death<br>Month <i>12</i> Day <i>23</i> Year <i>97</i>  |  | 3. Time of Death<br><i>7 AM</i>                                |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><i>Johns Hopkins Hosp.</i>   |  |   |  | 4b. City, Town, or Location of Death<br><i>Baltimore</i>  |  | 4c. County of Death<br><i>N/A</i>                              |  |
| Funeral<br>Director   | 5. Social Security Number<br><i>214-626850</i>   |  | 6. Sex<br><i>12 M 20 F</i>  | 7. Age (In yrs. last birthday)<br><i>45</i> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                         | 8. Date of Birth<br>(Month, Day, Year)<br><i>10-19-1952</i>    | 9. Birthplace (State or Foreign Country)<br><i>Maryland</i>  |
|   | Usual Residence of Decedent  |  |   |  | 10a. State<br><i>Maryland</i>   |  | 10b. County<br><i>N/A</i>                                      |  |
| To Be Completed by Funeral Director   | 10a. State<br><i>Maryland</i>  |  | 10b. County<br><i>N/A</i>   |  | 10c. City, Town or Location<br><i>Baltimore</i>   |  | 10d. Inside City Limits<br><i>12 Yes 20 No</i>                 |  |
|   | 10e. Street and Number<br><i>716 N. Milton Ave.</i>  |  |   |  | 10f. Zip Code<br><i>21205</i>   |  | 10g. Citizen of What Country?<br><i>U.S.A.</i>                 |  |
|   | 11. Marital Status<br><i>10 Never Married 20 Married 30 Widowed 40 Divorced</i>  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><i>10 Yes 20 No</i>                            |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><i>10 Yes 20 No</i> Specify:  |  | 14. Race - American Indian, Black, White, etc.<br><i>Black</i> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>7th</i> College (1-4 or 5+) <i>9</i>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Sanitor</i>                     |  | 16b. Kind of Business/Industry<br><i>Agua</i>                  |  |
|   | 17. Father's Name (First, Middle, Last)<br><i>Ernest Wheeler</i>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Laura Blake</i>   |  |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><i>Mrs. Laura Fugua</i>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>1835 N. Chester Street Balto. Md. 21213</i> |  |  |  |
|   | 20a. Method of Disposition<br><i>10 Burial 20 Cremation 30 Removal from State 40 Donation 50 Other (Specify)</i>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Mt. Zion Cem</i> |  | 20c. Location - City or Town, State<br><i>BALTO. CO. MD</i>   |  | 20d. Location - City or Town, State<br><i>BALTO. CO. MD</i>    |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Joseph L. Russ</i>   |  |   |  | 22. Name and Address of Facility<br><i>Joseph L. Russ Funeral Home 3232 W. North Ave. Balto. Md. 21216</i>                                      |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><i>a. Myocardial Infarction</i><br>Due to (or as a consequence of):<br><i>b. Dilated Cardiomyopathy</i><br>Due to (or as a consequence of):<br><i>c. Hypertension</i><br>Due to (or as a consequence of):<br><i>d. Hypercholesterolemia</i> |  |   |  |   |  |  | Approximate Interval Between Onset and Death   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>71p Amputation THUMB</i>  |  |   |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><i>10 Yes 20 No 30 Probably 40 Unknown</i> |
| 24a. Was an autopsy performed?<br><i>10 Yes 20 No</i>   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><i>10 Yes 20 No</i>   |   |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br><i>10 Yes 20 No</i>   |  | 26. Place of Death (Check only one)<br>Hospital: <i>10 Inpatient 20 ER/Outpatient 30 DOA</i> Other: <i>40 Nursing Home 50 Residence 80 Other (Specify)</i> |   |  |   |  |  |  |
| 27. Manner of Death<br><i>10 Natural 20 Accident 30 Suicide 40 Homicide 50 Pending Investigation 60 Could not be determined</i>   |  | 28a. Date of injury (Month, Day, Year)   |   | 28b. Time of injury<br><i>M</i>                  |   | 28c. Injury at Work?<br><i>10 Yes 20 No</i>            |  | 28d. Describe how injury occurred  |
| 29a. Certifier (Check only one)<br><i>10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</i> |  | 29b. Signature and title of certifier<br><i>[Signature]</i>  |   | 29c. License number<br><i>D25373</i>             |   | 29d. Date signed (Month, Day, Year)<br><i>12/30/97</i> |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>J Hunt, MD 2009 Druid Hill Ave, Balto. 21217</i>   |  |  |   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><i>DEC 31 1997</i>   |  | 32. Registrar's Signature<br><i>[Signature]</i>  |   |  |   |  |  |  |

Baltimore, Maryland 21215-0020

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Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39735

|  |   |                           |  |  |  |  |                                |   |  |  |  |
|--|---|---------------------------|--|--|--|--|--------------------------------|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><i>William McKinley Armstead Jr</i>                   |                           |  |  | 2. Date of Death<br>Month <i>12</i> Day <i>23</i> Year <i>1997</i> |  |                                |   | 3. Time of Death<br><i>6:30 A.M.</i>                                   |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>1629 Poplar Grove Street</i> |                           |  |  | 4b. City, Town, or Location of Death<br><i>Baltimore</i>           |  |                                |   | 4c. County of Death<br><i>N/A</i>                                      |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><i>214-26-2404</i>   |                           | 6. Sex<br><i>1 M 2 F</i>   |  | 7. Age (In yrs. last birthday)<br><i>68</i> Yrs.                   |  | If Under 1 Year<br>Months Days |   | If Under 24 Hrs.<br>Hours Min.   |  |  |
|  | 8. Date of Birth<br>Month, Day, Year<br><i>9-10-1929</i>  |                           |  |  | 9. Birthplace (State or Foreign Country)<br><i>Maryland</i>        |  |                                |   |  |  |  |
| Usual Residence of Decedent  |   |                           |  |  |  |  |                                |   |  |  |  |
| 10a. State<br><i>Maryland</i>  |   | 10b. County<br><i>N/A</i> |  | 10c. City, Town or Location<br><i>Baltimore</i>  |  |  |                                | 10d. Inside City Limits<br><i>1 Yes 2 No</i>                |  |  |  |
| 10e. Street and Number<br><i>1629 Poplar Grove St</i>  |   |                           |  | 10f. Zip Code<br><i>21216</i>  |  |  |                                | 10g. Citizen of What Country?<br><i>U.S.A.</i>              |  |  |  |
| 11. Marital Status<br><i>2 Married</i>   |   |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br><i>1 Yes 2 No</i><br>If Yes, Give Year or Dates: <i>WW II</i> |  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><i>1 Yes 2 No</i> Specify: |                                |   | 14. Race - American Indian, Black, White, etc.<br><i>Afro American</i> |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12th</i> College (1-4or 5+) <i>8</i>   |   |                           |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life; DO NOT use retired)<br><i>Chauffeur</i>                        |  |  |                                | 16b. Kind of Business/Industry<br><i>State of Md</i>        |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><i>William McKinley Armstead</i>  |   |                           |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Estelle Moore</i>  |  |  |                                |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>Mrs. LaRue Armstead (Wife)</i>  |   |                           |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>1629 Poplar Grove St. Baltimore Md 21216</i>     |  |  |                                |   |  |  |  |
| 20a. Method of Disposition<br><i>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</i>  |   |                           |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Woodlawn Cem</i>  |  |  |                                | 20c. Location - City or Town, State<br><i>Balto. Co. Md</i> |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Joseph L. Russ</i>   |   |                           |  | 22. Name and Address of Facility<br><i>Joseph L. Russ Funeral Home<br/>2225 W. North Ave. Balto. Md. 21216</i>                                       |  |  |                                |   |  |  |  |
| 23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |                           |  |  |  |  |                                |   |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)<br><i>COLON CANCER</i>   |   |                           |  |  |  |  |                                |   |  |  |  |
| a. Due to (or as a consequence of):  |   |                           |  |  |  |  |                                |   |  |  |  |
| b. Due to (or as a consequence of):  |   |                           |  |  |  |  |                                |   |  |  |  |
| c. Due to (or as a consequence of):  |   |                           |  |  |  |  |                                |   |  |  |  |
| d. Due to (or as a consequence of):  |   |                           |  |  |  |  |                                |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |                           |  |  |  |  |                                |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><i>1 Yes 2 No 3 Probably 4 Unknown</i>   |   |                           |  |  |  |  |                                |   |  |  |  |
| 24a. Was an autopsy performed?<br><i>1 Yes 2 No</i>  |   |                           |  |  |  |  |                                |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><i>1 Yes 2 No</i>   |   |                           |  |  |  |  |                                |   |  |  |  |
| 25. Was case referred to medical examiner?<br><i>1 Yes 2 No</i>  |   |                           |  | 26. Place of Death (Check only one)<br>Hospital: <i>1 Inpatient 2 ER/Outpatient 3 DOA</i> Other: <i>4 Nursing Home 5 Residence 8 Other (Specify)</i> |  |  |                                |   |  |  |  |
| 27. Manner of Death<br><i>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</i>  |   |                           |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><i>M</i>  |                                | 28c. Injury at Work?<br><i>1 Yes 2 No</i>                   |  | 28d. Describe how injury occurred                      |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |                           |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |                                |   |  |  |  |
| 29a. Certifier (Check only one)<br><i>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</i> |   |                           |  | 29b. Signature and title of certifier<br><i>Nathan Scott, MD</i>   |  |  |                                | 29c. License number<br><i>D34484</i>                        |  | 29d. Date signed (Month, Day, Year)<br><i>12-29-97</i> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>NATHAN SCOTT, M.D. 1000 E. EAGER ST. BALTIMORE, MD 21202</i>  |   |                           |  |  |  |  |                                |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><i>DEC 31 1997</i>  |   |                           |  | 32. Registrar's Signature<br><i>Jillian Davidson-Randall</i>   |  |  |                                |   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

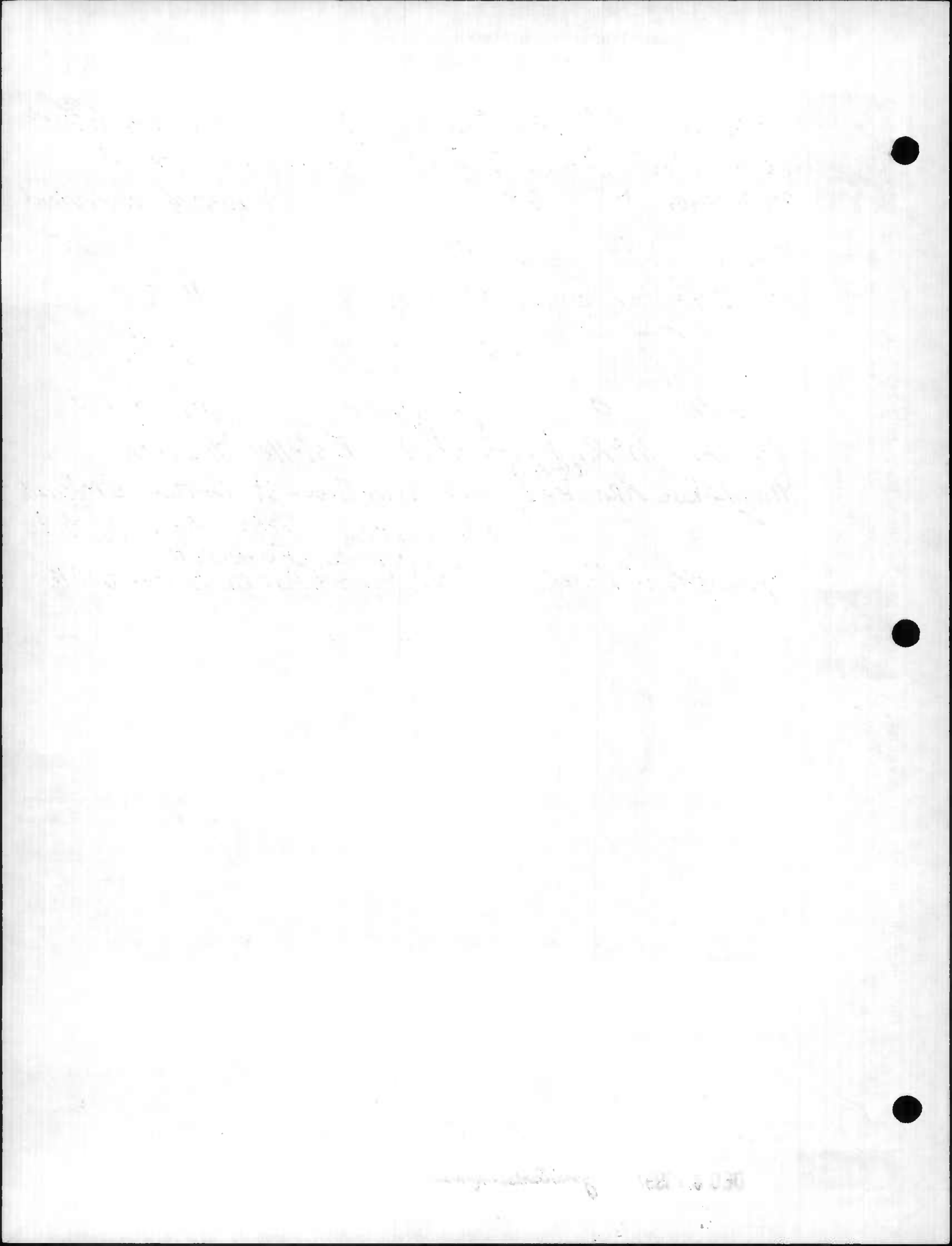
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39736

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

James Rudell Alder

2. Date of Death

Dec. 25, 1997

3. Time of Death

740am

4a. Facility Name (If not institution, give street and number)

16 Village Rd.

4b. City, Town, or Location of Death

Pikesville

4c. County of Death

Baltimore Co.

5. Social Security Number

220-18-3433

6. Sex

1X M 2 ☐ F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 22, 1925

9. Birthplace (State or Foreign Country)

Balto. Co. Md.

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Pikesville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

16 Village Rd.

10f. Zip Code

21208

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WW213. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12 Grade

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Self Employed

17. Father's Name (First, Middle, Last)

Charles Alder

18. Mother's Name (First, Middle, Maiden Surname)

Julie May

19a. Informant's Name/Relationship (Type, Print)

Marjorie A. Alder / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16 Village Rd. Pikesville, Md. 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Druid Ridge Cemetery

Date

12/29/97

20c. Location - City or Town, State

Pikesville, Md.

21. Signature of Funeral Service Licensee

*Fun B Eline*

22. Name and Address of Facility

11824 Reisterstown Rd.  
ELINE FUNERAL HOME Reisterstown, Md. 2113623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. *Coronary Occlusion*

Due to (or as a consequence of):

b. *Arteriosclerotic Cardio Vascular Disease*

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*2nd to 3rd Degree Burns of Rt Chest  
Rt Foot + Knee + Scrotum + Penis*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician2 ☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner as stated.

29b. Signature and title of certifier

*Charles F O'Donnell MD*

29c. License number

1-D9383

29d. Date signed (Month, Day, Year)

December 26, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles F O'Donnell MD - 111 Hamlet Hill Rd Baltimore 21210

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

*Julia Davidson-Randall*State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

[illegible]





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39738

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARGARET L. ALBRECHT

2. Date of Death

Month Day Year  
DECEMBER 28, 1997

3. Time of Death

12:20 PM

4e. Facility Name (If not institution, give street and number)

ANNE ARUNDEL GENERAL HOSPITAL

4b. City, Town, or Location of Death

ANNAPOLIS

4c. County of Death

ANNE ARUNDEL

Funeral  
Director

5. Social Security Number

212-22-3866

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
MARCH 4, 1926

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10e. State

MD

10b. County

ANNE ARUNDEL

10c. City, Town or Location

SEVERNA PARK

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

502 NARBOROUGH COURT

10f. Zip Code

21146

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

H/S GRADUATE

College (1-4or 5+)

17. Father's Name (First, Middle, Last)

HENRY BAUMGARTNER

18. Mother's Name (First, Middle, Maiden Surname)

LORIS HYLAND

19a. Informant's Name/Relationship (Type, Print)

HARRY ALBRECHT (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7797 GABRIEL GARTH - SEVERN, MD 21144

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

LOUDON PARK CEMETERY

Date

12/31/97

20c. Location - City or Town, State

BALTIMORE

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HUBBARD FUNERAL HOME INC.

4107 WILKENS AVENUE-BALTIMORE, MD 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. brain stem stroke

Due to (or as a consequence of):

b. diabetic

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

1 day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
Investigation6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29e. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D38158

29d. Date signed (Month, Day, Year)

12/28/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Lisa A DiMarzio MA 2003 Medical Parkway, Suite 100 ANNAPOLIS, MD

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

21901

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial/transfer

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

87 39739

|  |  |   |  |   |  |  |   |   |  |
|--|--|---|--|---|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>RUTH C. AHLFELDT                                 |   |  |   | 2. Date of Death<br>Month Day Year<br>DEC 23, 1997 |  | 3. Time of Death<br>5:30 PM                         |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>HAMMONDS LANE NURSING HOME |   |  |   | 4b. City, Town, or Location of Death<br>BALTIMORE  |  | 4c. County of Death<br>ANNE ARUNDEL                 |   |  |
| Funeral<br>Director  | 5. Social Security Number<br>212-09-4733   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br>86 Yrs.          |  | 8. Date of Birth (Month, Day, Year)<br>OCT 30, 1911 |   |  |
|  | 9. Birthplace (State or Foreign Country)<br>BALTO., MD                                       |   | 10a. State<br>MD   |   | 10b. County<br>BALTIMORE                           |  | 10c. City, Town or Location<br>BALTIMORE            |   |  |
| Usual Residence of Decedent  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br>4406 NORFEN ROAD  |  | 10f. Zip Code<br>21227   |   | 10g. Citizen of What Country?<br>U.S.A. |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE   |   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11TH GRADE<br>College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>CLERK  |  | 16b. Kind of Business/Industry<br>SOCIAL SECURITY ADM.  |  |  |   |   |  |
| 17. Father's Name (First, Middle, Last)<br>ALBERT AHLFELDT   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>LENORA HEINKLE   |  |  |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>VIRGINIA M. DORSEY (NIECE)   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4406 NORFEN ROAD - BALTIMORE, MD. 21227  |  |  |   |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>BALTIMORE CEMETERY  |  | 20c. Location - City or Town, State<br>12/26/97 BALTIMORE   |  |  |   |   |  |
| 21. Signature of Funeral Service Licensee<br>Jackie D. Shannon   |  | 22. Name and Address of Facility<br>HUBBARD FUNERAL HOME INC.<br>4107 WILKENS AVENUE-BALTIMORE, MD 21229  |  |   |  |  |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | a. CEREBROVASCULAR ACCIDENT.<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d.  |  | Approximate Interval Between Onset and Death<br>Immediate   |  |  |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |   |  |
|  |  |   |  |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |  |
|  |  |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 28d. Describe how Injury occurred       |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                      |  | 29b. Signature and title of certifier   |  | 29c. License number<br>20091  |  | 29d. Date signed (Month, Day, Year)<br>Dec 24 1997   |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>DR. SYED M.A. RIAZ - 800 N. HAMMONDS FERRY ROAD - SUITE-1-C-LINTHICUM, MD. 21090   |  |   |  |   |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br>DEC 31 1997   |  | 32. Registrar's Signature<br>Julia Davidson-Randall   |  |   |  |  |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

THE [illegible] OF [illegible]

AND [illegible]

IN [illegible]

BY [illegible]

OF [illegible]

AND [illegible]

IN [illegible]

AND [illegible]

IN [illegible]

AND [illegible]

AND [illegible]

AND [illegible]

AND [illegible]

AND [illegible]

AND [illegible]

AND [illegible]

AND [illegible]

AND [illegible]

AND [illegible]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39740

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MALCOLM S. ANSTINE

2. Date of Death

Month

Day

Year

Dec 21

1997

3. Time of Death

05:00 AM

4a. Facility Name (If not institution, give street and number)

St Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

212-36-6065

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

59

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

JULY 19, 1938

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

ANNE ARUNDEL

10c. City, Town or Location

GLEN BURNIE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

19 KEMPTON ROAD

10f. Zip Code

21060

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12TH GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

SERVICE TECH ENGINEER

16b. Kind of Business/Industry

PHONE COMPANY

17. Father's Name (First, Middle, Last)

JAMES SCOTT ANSTINE

18. Mother's Name (First, Middle, Maiden Surname)

ELIZABETH FOOSE

19a. Informant's Name/Relationship (Type, Print)

NORMA ANSTINE (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19 KEMPSTON ROAD - GLEN BURNIE, MD. 21060

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

DRUID RIDGE CEMETERY

Date

12/24/97

20c. Location - City or Town, State

PIKESVILLE, MD

21. Signature of Funeral Service Licensee

Jackie A. Shannon

22. Name and Address of Facility

HUBBARD FUNERAL HOME INC.

4107 WILKENS AVENUE-BALTIMORE, MD

21229

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
stroke, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Respiratory failure  
Due to (or as a consequence of):b. Pneumonia  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

10 mins

1 week

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Dr. Shannon Medical Resident

29c. License number

P11079

29d. Date signed (Month, Day, Year)

Dec 21 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. Shannon Penthouse 901 Caxon Ave Baltimore, md 21229

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

John Shannon-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transitNAME: MALCOLM, Anstine  
Division of Vital Records, P.O. Box 68760,  
Baltimore, Maryland 21229



FELIX BUCCI

ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39741

|   |  |   |   |   |  |  |   |   |
|---|--|---|---|---|--|--|---|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>FELIX J. BUCCI JR.</b>  |   |   |   | 2. Date of Death<br>Month Day Year<br><b>DECEMBER 21 1997</b>  |  | 3. Time of Death<br><b>2340 P</b>                                       |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>FRANKLIN SQUARE HOSPITAL</b>  |   |   |   | 4b. City, Town, or Location of Death<br><b>ESSEX</b>   |  | 4c. County of Death<br><b>BALTIMORE</b>                                 |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>216-50-0916</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>51 Yrs.</b>  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>AUG. 27, 1946</b>             | 9. Birthplace (State or Foreign Country)<br><b>MD.</b>                |
|   | Usual Residence of Decedent  |   |   |   |  |  |   |   |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD.</b>   | 10b. County<br><b>BALTIMORE</b>   | 10c. City, Town or Location<br><b>ROSEDALE</b>  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |
|   | 10e. Street and Number<br><b>9633 BARON PLACE</b>  |   |   | 10f. Zip Code<br><b>21237</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                             |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4or 5+) <b>4</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CEMENT FINISHER</b>               |   | 16b. Kind of Business/Industry<br><b>BUILDING CONSTRUCTION</b>   |  |   |   |
| 17. Father's Name (First, Middle, Last)<br><b>FELIX BUCCI SR.</b>   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>CARMELA INNANTUONO</b>  |  |  |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>SHARON BUCCI (WIFE)</b>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9633 BARON PLACE ROSEDALE 21237 MD.</b> |  |  |   |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>OAKHAWN CEM.</b>   |  | 20c. Location - City or Town, State<br><b>12/23/97 BALTO. MD.</b>  |   | Approximate Interval Between Onset and Death                          |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |  |   |   | 22. Name and Address of Facility<br><b>DELLA NOCE + SONS FUNERAL HOME<br/>322 S. HIGH ST. BALTO 21202 MD.</b>                               |  |  |   |   |
| Physician<br>/Medical<br>Examiner   | 23. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.           |   |   |   |  |  |   |   |
|   | Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Multiple Injuries</b><br>Due to (or as a consequence of):   |   |   |   |  |  |   |   |
|   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>f. _____<br>Due to (or as a consequence of): |   |   |   |  |  |   |   |
|   | g. _____<br>Due to (or as a consequence of):   |   |   |   |  |  |   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |   |
|   |  |   |   |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |
|   |  |   |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |  |   |   |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)<br><b>12-20-97</b>   |   | 28b. Time of Injury<br><b>22 10 M</b>   |  | 28c. Injury et Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred<br><b>pedestrian struck by Auto</b> |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>roadway</b>  |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Philadelphia Rd</b>   |   |   |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><i>[Signature]</i>   |   | 29c. License number<br><b>O.C.M.E</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>DECEMBER 21, 1997</b>  |   |   |
| 30. Name and address of person who completed cause of death (Item 28e) (Type, Print)<br><b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>  |  |   |   |   |  |  |   |   |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |   |   |  |  |   |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39742

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HILDA MARGARET BERTOLOI

2. Date of Death

December 28 1997

3. Time of Death

12:45 AM

4a. Facility Name (If not institution, give street and number)

GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral  
Director

5. Social Security Number

217-12-0812

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JAN. 9, 1922

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

4221 BAYONNE AVE

10f. Zip Code

21234

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 YRS.

College (1-4 or 5+)

2 YRS.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

AT HOME

17. Father's Name (First, Middle, Last)

OTTO HUGO de FRIZZ

18. Mother's Name (First, Middle, Maiden Surname)

HILDA GUNKET

19a. Informant's Name/Relationship (Type, Print)

ELISA P. FOSLER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2711 ROBERT ROAD PARKVILLE MARYLAND 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HOLY ROSARY

Data

DEC 31, 1997

20c. Location - City or Town, State

BALTIMORE MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

EVANS CHARLOTTA MEMORIES 21234  
8800 HARFORD ROAD PARKVILLE, MARYLAND

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Massive Cerebrovascular Stroke

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

36 Hrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Myocardial Infarction

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

P10584

29d. Date signed (Month, Day, Year)

DECEMBER 28, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Jihad Youssif

5601 Loch Raven Blvd. Baltimore, Maryland 21239

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

Jude Davidson-Pandell

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

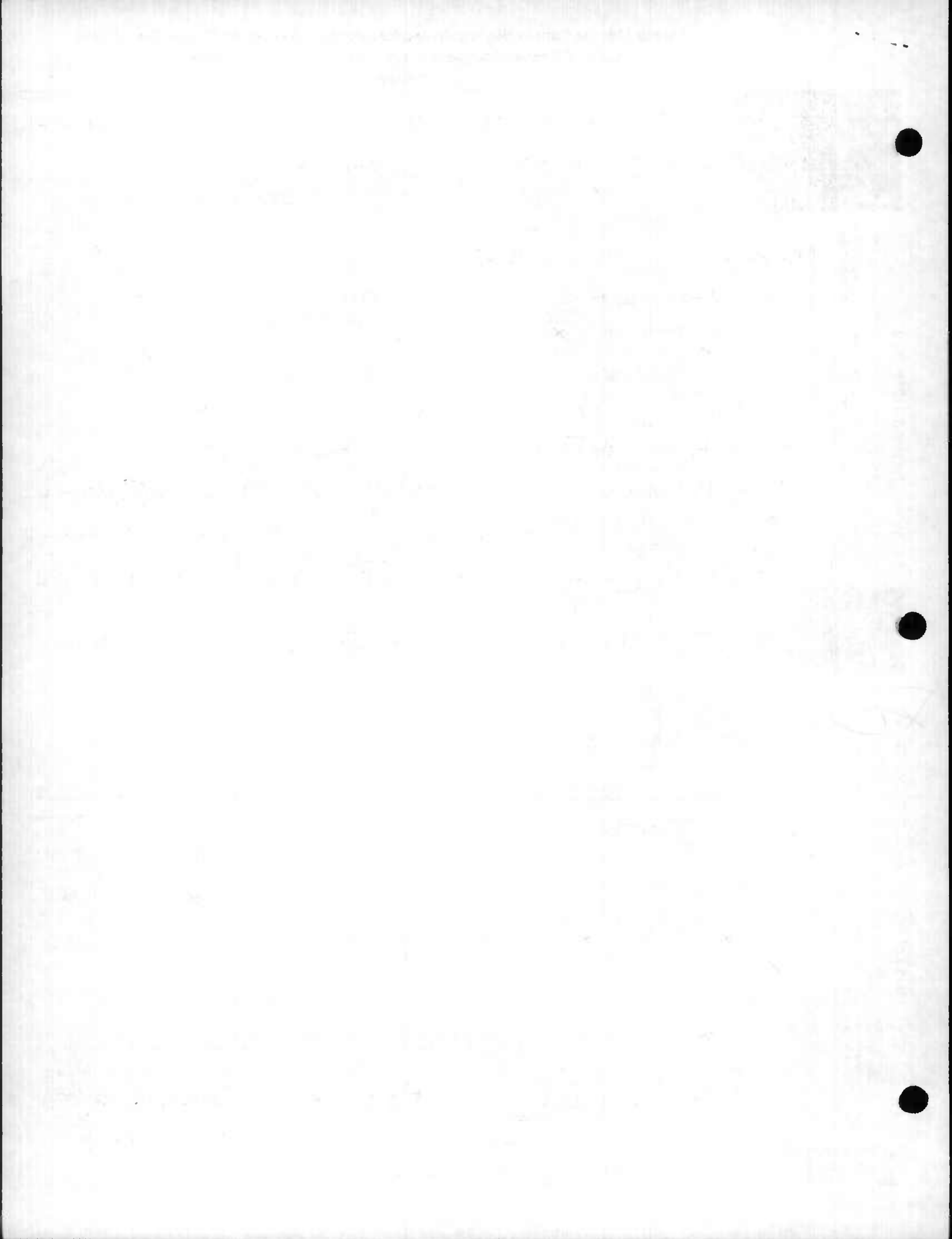
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39743

|   |   |  |   |   |  |  |   |   |
|---|---|--|---|---|--|--|---|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>FANNIE BRYANT</b>  |  |   |   | 2. Date of Death<br>Month Day Year<br><b>DECEMBER 23 1997</b>  |  | 3. Time of Death<br><b>2:40 P.M.</b>  |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>NORTHWEST HOSPITAL CENTER</b>  |  |   |   | 4b. City, Town, or Location of Death<br><b>RANDALLSTOWN</b>  |  | 4c. County of Death<br><b>BALTIMORE</b>   |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>244-56-4085</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F             | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>12-15-1917</b>                                       |   | 9. Birthplace (State or Foreign Country)<br><b>N.C.</b> |
|   | Usual Residence of Decedent   |  |   |   |  |  |   |   |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>N/A</b>  | 10c. City, Town or Location<br><b>Baltimore</b>   |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |   |
|   | 10e. Street and Number<br><b>4008 KATHLAND AVE.</b>   |  |   | 10f. Zip Code<br><b>21207</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Afro American</b> |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7th</b> College (14 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Domestic</b>                      |   | 16b. Kind of Business/Industry<br><b>Private Family</b>  |  |   |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>John Ford</b>   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Josie Ford</b>   |  |   |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Sarah Byrd</b>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4008 KATHLAND AVE. Baltimore Md. 21207</b>   |  |   |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Necropolis, cemetery, crematory or other place)<br><b>Vashell Memorial Gardens</b>                                     |   | 20c. Location - City or Town, State<br><b>Baltimore Md.</b>  |  |   |   |
|   | 21. Signature of Funeral Service Licensee<br><b>Joseph L. Russ</b>  |  | 22. Name and Address of Facility<br><b>Joseph L. Russ FUNERAL HOME<br/>2332 W. North Ave. Baltimore Md. 21216</b>                                 |   |  |  |   |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                             |  |   |   |  |  |   |   |
|   | Physician<br>/Medical<br>Examiner   | Immediate Cause (Final disease or condition resulting in death)                        |   | a. <b>ACUTE RENAL FAILURE</b>   |  |  |   | DAYS  |
|   |   | Due to (or as a consequence of):   |   |   |  |  |   |   |
|   |   | b. <b>DIABETIC NEPHROPATHY</b>   |   |   |  | YEARS  |   |   |
|   |   | Due to (or as a consequence of):   |   |   |  |  |   |   |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |   | c.   |   |   |  |  |   |   |
|   |   | Due to (or as a consequence of):   |   |   |  |  |   |   |
|   |   | d.   |   |   |  |  |   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DIABETES</b><br><b>DEMENTIA</b>  |   |  |   |   |  |  |   |   |
| 25. Was cause related to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   | 28d. Describe how injury occurred                       |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                   |   |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |   |  |  |   |   |
| 29b. Signature and title of certifier<br><b>K.S. RAO M.D.</b>   |   |  |   | 29c. License number<br><b>D43462</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>DECEMBER 23 1997</b>                                 |   |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>NORTHWEST HOSPITAL CENTER RANDALLSTOWN MD</b>  |   |  |   |   |  |  |   |   |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>   |   | 32. Registrar's Signature<br><b>[Signature]</b>  |   |   |  |  |   |   |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

3



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39744

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Anna M Brandt

2. Date of Death

Dec 28 1999

3. Time of Death

7:10 pm

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

298-18-4955

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74

If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)

SEPT. 14, 1923

9. Birthplace (State or Foreign  
Country)

OHIO

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

GLEN BURNIE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

901 POINT PLEASANT RD.

10f. Zip Code

21060

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

FACTORY WORKER

16b. Kind of Business/Industry

WESTINGHOUSE

17. Father's Name (First, Middle, Last)

ELMER E. PYLE

18. Mother's Name (First, Middle, Maiden Surname)

SARAH (UNKNOWN)

19a. Informant's Name/Relationship (Type, Print)

ROBERT J. MCHALE., SR. / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

820 MEADOW RD., SEVERN, MARYLAND 21144

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

METRO CREMATORY, INC.

Date

DEC. 31,  
1997

20c. Location - City or Town, State

CATONSVILLE, MARYLAND

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

KIRKLEY-RUDDICK FUNERAL HOME, P.A.  
421 CRAIN HWY., S.E., GLEN BURNIE, MD 2106123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. atherosclerotic coronary vascular disease

unknown

Due to (or as a consequence of):

b. chronic obstructive pulmonary disease

unknown

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

[Signature] Jeffrey Buggs MD

29c. License number

D28640

29d. Date signed (Month, Day, Year)

Dec. 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2414 Hightee Ct. Crofton MD 21114

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

[Signature] John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the funeral-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

*[Faint handwritten signature]*

1941 10 10

1941 10 10

1941 10 10

1941 10 10

1941 10 10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Item: 27 Per MEO Film G-754 12-31-97RC

Reg. No.

97 39745

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT ALLEN BLOODWORTH

2. Date of Death

Month Day Year  
December 29, 1997

3. Time of Death

5:45 am

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

447-78-2730

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

32

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 30, 1965

9. Birthplace (State or Foreign Country)

Oklahoma

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2824 Calvert St.

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Student

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

William A. Bloodworth, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Karen Janet

19a. Informant's Name/Relationship (Type, Print)

Karen Bloodworth

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1112 S. Gray, Stillwater, OK 74074

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory

Date

12/31/97

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ALTENBURG FUNERAL HOME, P.A.

6009 Harford Rd., Baltimore, MD 21214

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Heroin Overdose

Due to (or as a consequence of):

2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. IV Drug Abuse

Due to (or as a consequence of):

2 days

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☐ Natural ☐ Pending investigation  
☒ Accident ☐ Suicide ☐ Homicide  
☒ Could not be determined

28a. Date of Injury

(Month, Day Year)  
December 27, 1997

28b. Time of Injury

UNK M

28c. Injury et Work?

☐ Yes ☒ No

28d. Describe how injury occurred

UNKNOWN

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2824 Calvert St. Baltimore MD 21218

29e. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

AT2438946 C12

29d. Date signed (Month, Day, Year)

DECEMBER 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KENNETH G. FULP UNION MEMORIAL HOSPITAL BALTIMORE MARYLAND

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

State  
RegistrarBaltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be completed and signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

37 39746

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Gerald I. Byrnes

2. Date of Death

Month

Day

Year

December

29

1997

3. Time of Death

01:55 am

4a. Facility Name (If not institution, give street and number)

ST AGNES HEALTH CARE

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

219-05-4236

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 26, 1912

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10a. Street and Number

909 Wilton Drive

10f. Zip Code

21227

10g. Citizen of What Country?

United States

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12 +

College (14 or 5+)

1

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Civil Servant

16b. Kind of Business/Industry

City Employee

17. Father's Name (First, Middle, Last)

Andrew I. Byrnes

18. Mother's Name (First, Middle, Maiden Surname)

Bridget Tiernan

19a. Informant's Name/Relationship (Type, Print)

Francis J. Klebe, Sr./Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

525 Retford Drive, Severna Park MD 21146

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

New Cathedral Cemetery, December 31, 1997

Data

20c. Location - City or Town, State

Baltimore Maryland

21. Signature of Funeral Service Licensee

Victor P. Doda, Jr.

22. Name and Address of Facility

Charles L. Stevens Funeral Home, Inc.  
1501 East Fort Avenue, Baltimore MD 21230

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

Approximate Interval Between Onset and Death

minutes

Due to (or as a consequence of):

b. Intracranial hemorrhage

days

Due to (or as a consequence of):

c. Congestive heart failure

months

Due to (or as a consequence of):

d. Chronic obstructive pulmonary disease

months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Arrhythmias

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Rupesh Parikh

M.D.

29c. License number

P11698

29d. Date signed (Month, Day, Year)

December 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rupesh Parikh

900 Caton Ave

Baltimore, MD

21229

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

NAME: BYRNES, GERALD I

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39747

Amended #8 per FH G754 12/12/97 EW

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mildred Boldowsky

2. Date of Death

December 17 1997

3. Time of Death

5:40 PM

4a. Facility Name (If not institution, give street and number)

Mercy Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

218-10-9487

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

78

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

3/03/19

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1542 Latrobe Park Terrace

10f. Zip Code

21230

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9th

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Albert Lopez

18. Mother's Name (First, Middle, Maiden Surname)

Katherine R. Cross

19a. Informant's Name/Relationship (Type, Print)

Peter Boldowsky / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1542 Latrobe Park Terrace, Baltimore, MD 21230

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery December 20, 1997 Baltimore City

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

P. D. D.

22. Name and Address of Facility

Charles L. Stevens Funeral Home, Inc.  
1501 E. Fort Avenue, Baltimore Maryland 21230

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Lymphoma

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 years

Sequently list conditions, if any, leading to immediate cause. Enter underlying cause. (Disease or injury that initiated events resulting in death) Last

b. Superior vena caval syndrome

Due to (or as a consequence of):

5 days

c. Superior vena caval Thrombus

Due to (or as a consequence of):

5 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Vijay Pethkar M.D.

29c. License number

D50853

29d. Date signed (Month, Day, Year)

December 17, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vijay Pethkar 301 St. Paul Place, Baltimore MD 21202.

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

John Davidson-Randall

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the document is a letter from the President of the United States to the Secretary of the Navy, dated 18th March 1881. The letter is signed by the President and is addressed to the Secretary of the Navy.

2. The second part of the document is a letter from the Secretary of the Navy to the President, dated 18th March 1881. The letter is signed by the Secretary of the Navy and is addressed to the President.

3. The third part of the document is a letter from the Secretary of the Navy to the President, dated 18th March 1881. The letter is signed by the Secretary of the Navy and is addressed to the President.

4. The fourth part of the document is a letter from the Secretary of the Navy to the President, dated 18th March 1881. The letter is signed by the Secretary of the Navy and is addressed to the President.

5. The fifth part of the document is a letter from the Secretary of the Navy to the President, dated 18th March 1881. The letter is signed by the Secretary of the Navy and is addressed to the President.

6. The sixth part of the document is a letter from the Secretary of the Navy to the President, dated 18th March 1881. The letter is signed by the Secretary of the Navy and is addressed to the President.

7. The seventh part of the document is a letter from the Secretary of the Navy to the President, dated 18th March 1881. The letter is signed by the Secretary of the Navy and is addressed to the President.

8. The eighth part of the document is a letter from the Secretary of the Navy to the President, dated 18th March 1881. The letter is signed by the Secretary of the Navy and is addressed to the President.

9. The ninth part of the document is a letter from the Secretary of the Navy to the President, dated 18th March 1881. The letter is signed by the Secretary of the Navy and is addressed to the President.

10. The tenth part of the document is a letter from the Secretary of the Navy to the President, dated 18th March 1881. The letter is signed by the Secretary of the Navy and is addressed to the President.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 39748

Physician  
/Medical  
Examiner

Funeral  
Director

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>GRIGORIY DAVYDOVICH BOGATYREV</b>   |  |   |  | 2. Date of Death<br>Month <b>Dec</b> Day <b>26</b> Year <b>97</b>  |  | 3. Time of Death<br><b>2:30PM</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>SINAI HOSPITAL</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>N/A</b>   |  |
| 5. Social Security Number<br><b>220-37-6595</b>  |  | 6. Sex<br><b>1</b> M <b>2</b> F   | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                   | 8. Date of Birth<br>Month Day Year<br><b>JULY 3, 1911</b>   | 9. Birthplace (State or Foreign Country)<br><b>UKRAINE</b> |
| Usual Residence of Decedent  |  |   |  |  |  |   |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  | 10d. Inside City Limits<br><b>XX</b> Yes <b>2</b> No  |  |
| 10e. Street and Number<br><b>3615 FORDS LANE, APT. 215</b>   |  |   |  | 10f. Zip Code<br><b>21215</b>  |  | 10g. Citizen of What Country?<br><b>RUSSIA</b>  |  |
| 11. Marital Status<br><b>XX</b> Married<br><input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>XX</b> No Specify:            |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CHIEF ADMINISTRATOR</b>   |  |  | 16b. Kind of Business/Industry<br><b>THEATER</b> |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>BENTSION DAVID BOGATYREV</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARIA UNKNOWN</b>  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>LEYA BOGATYREVA / WIFE</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3615 FORDS LA, #215; BALTIMORE, MD 21215</b> |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>BALTIMORE HEBREW</b>   |  | Date<br><b>12-29-1997</b>  |  | 20c. Location - City or Town, State<br><b>REISTERSTOWN, MD</b>  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS, INC.</b><br><b>8900 REISTERSTOWN RD; PIKESVILLE, MD 21208</b>                    |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>acute coronary insufficiency</b><br>Due to (or as a consequence of):<br>b. <b>coronary artery disease</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d. |  |   |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown |  |
|  |  |   |  |  |  | 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No  |  |
|  |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No               |  |
| 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No  |  |
|  |  | 28d. Describe how Injury occurred   |  |  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br>   |  |  |  | 29c. License number<br><b>D34878</b>  |  |
|  |  |   |  | 29d. Date signed (Month, Day, Year)<br><b>12/27/97</b>   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>VICTORIA V. TSINGBERG SINAI HOSPITAL</b>  |  |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>  |  |   |  | 32. Registrar's Signature<br>  |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39749

HARRY

BALL Items: 23a part I, II, 27 per MEO G-755 1/14/98 dh

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Harry J. Ball

2. Date of Death

Month Day Year  
DECEMBER 5, 1997

3. Time of Death

5:50P.M.

4a. Facility Name (If not institution, give street and number)

616 N. GOLD STREET

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

231-20-4868

6. Sex

X M 2 F

7. Age (In yrs. last birthday)

69

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

06 16 1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

X Yes 2 No

10e. Street and Number

616 Gold Street

10f. Zip Code

21217

10g. Citizen of What Country?

U.S.A.

11. Marital Status

X Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 Yes 2 No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Construction

16b. Kind of Business/Industry

Construction Worker

17. Father's Name (First, Middle, Last)

Joseph Ball

18. Mother's Name (First, Middle, Maiden Surname)

Edna Ball

19a. Informant's Name/Relationship (Type, Print)

Beatrice Wilkerson/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

229 N. Mount Street, Baltimore, Maryland 21217

20a. Method of Disposition

1 X Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion Cemetery

Date

12/20/97 Landsdowne, Md.

21. Signature of Funeral Service Licensee

H. G. Close

22. Name and Address of Facility

William C. Brown Community Funeral Home  
1206 W. North Avenue, Baltimore, Maryland 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

GASTRIC ADENOCARCINOMA

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed?

1 X Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 X Yes 2 No

25. Was case referred to medical examiner?

1 X Yes 2 No

26. Place of Death (Check only one)

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 X Natural 5 Pending Investigation  
2 Accident 6 Could not be determined  
3 Suicide 4 Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Stephen S. Radentz, M.D.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

DECEMBER 6, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen S. Radentz, M.D. 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39750

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ANNIE BERTHA BATZER

2. Date of Death  
Month Day Year

December 24 1997

3. Time of Death

6:00 PM

4a. Facility Name (If not institution, give street and number)

Bent's Elder care Caton Manor

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

216-50-4085

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

NOV 27, 1904

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

448 FURROW STREET

10f. Zip Code

21223

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
9TH GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

GEORGE BEYER

18. Mother's Name (First, Middle, Maiden Surname)

KATHERINE MALOUS

19a. Informant's Name/Relationship (Type, Print)

AUGUSTA D. KESTLER(SISTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

448 FURROW STREET - BALTIMORE, MD 21223

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WESTERN CEMETERY

Date

12/29/97

20c. Location - City or Town, State

BALTIMORE

21. Signature of Funeral Service Licensee

Jackie H. Shannon

22. Name and Address of Facility

HUBBARD FUNERAL HOME INC.

4107 WILKENS AVENUE-BALTIMORE, MD 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Pneumonia

e. Due to (or as a consequence of):

Parkinsonism

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 Week

2 Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Suspected Carcinoma of the Lung

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Whynne M. Attending Doctor

29c. License number

D21684

29d. Date signed (Month, Day, Year)

12-26-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C.N. LYRIAC, M.D., 8109 RITCHIE HWY, PASADENA, MD 21122

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
RegistrarBATZER, ANNIE B.  
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39751

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DOROTHY N. BENSON

2. Date of Death

Month Day Year  
DEC. 24 1997

3. Time of Death

3:30 P.M.

4a. Facility Name (If not institution, give street and number)

SALISBURY CENTER:GENESIS ELDERCARE

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number

578-20-5105

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Apr. 5, 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

U.S. Route #50

10f. Zip Code

21804

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

Collega (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Builder

16b. Kind of Business/Industry

Private Company

17. Father's Name (First, Middle, Last)

W. Ray Gibbons

18. Mother's Name (First, Middle, Maiden Surname)

Hester MacFarlane

19a. Informant's Name/Relationship (Type, Print)

Barbara Jones/Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

931 Sumac Cir. Salisbury, MD 21804

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Columbia Gardens

Date

12/27/97

20c. Location - City or Town, State

Arlington, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ives-Pearson Funeral Homes  
2847 Wilson Blvd. Arlington, VA 22201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Coronary artery disease*  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

*yes*

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *CHF*  
Due to (or as a consequence of):

*yes*

c. *Parkinson's disease*  
Due to (or as a consequence of):

*yes*

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILLIAM ROBINS

200 Civic Avenue, Salisbury, MD 21804

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

*Julia Davidson-Randall*

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

Division of Vital Records, P.O. Box 68760



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39752

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

FRED NUNDO BERTA

2. Date of Death

Month 12 Day 26 Year 97 12:43 AM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

FALSTON GENOM Hospital

4b. City, Town, or Location of Death

FALSTON

4c. County of Death

HARFORD

5. Social Security Number

206-05-9330

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Oct. 10, 1920

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10e. State

Maryland

10b. County

Harford

10c. City, Town or Location

Abingdon

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

302 A Tall Pines Court

10f. Zip Code

21009

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8th.

College (1-4 or 5+)  
n/a

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Rod & Wire Mill

16b. Kind of Business/Industry

Bethlehem Steel Corporation

17. Father's Name (First, Middle, Last)

Paul Berta

18. Mother's Name (First, Middle, Maiden Surname)

Catrina Merlo

19a. Informant's Name/Relationship (Type, Print)

Janet McDaniel (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

357 Quilting Way BelAir, Md. 21015

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Highview Memorial Grds.

Date

12/29/97

20c. Location - City or Town, State

Fallston, Maryland 21047

21. Signature of Funeral Service Licensee

E. F. Lassahn

22. Name and Address of Facility

E. F. Lassahn Funeral Home  
11750 Belair Road Kingsville, Md. 21087

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

6 Hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CARDIOGENIC SHOCK

Due to (or as a consequence of):

1 Hour

c. DIABETES MELLITUS

Due to (or as a consequence of):

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

JAY M LANG, D.O.

29c. License number

H44463

29d. Date signed (Month, Day, Year)

DECEMBER 26, 1997

30. Name and address of person who completed cause of death (item 23e) (Type, Print)

JAY M LANG, DO 615 W MARSHALL ROAD BEL AIR, MD

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

Jane Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Item: 4c per MD G-755 1/7/98 dh

Certificate of Death

Reg. No.

97 39753

|   |  |  |  |  |  |  |  |   |   |  |
|---|--|--|--|--|--|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Abraham Bates</b>   |  |  |  | 2. Date of Death<br>Month <b>December</b> Day <b>18</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>8:50 AM</b>   |   |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>14949 Old Frederick Road</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Woodbine</b>  |  | 4c. County of Death<br><b>Carroll Howard</b>                               |   |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>132-10-1554</b>  |  | 6. Sex<br><b>1</b> M <b>2</b> F  | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                   | 8. Date of Birth<br>(Month, Day, Year)<br><b>Feb. 5, 1916</b>              | 9. Birthplace (State or Foreign Country)<br><b>Mongolia</b>   |   |  |
|   | Usual Residence of Decedent  |  |  |  |  |  |  |   |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Carroll HOWARD</b>   |  | 10c. City, Town or Location<br><b>Woodbine</b>   |  |  | 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No   |   |  |
|   | 10e. Street and Number<br><b>14949 Old Frederick Road</b>  |  |  |  | 10f. Zip Code<br><b>21797</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                             |   |   |  |
|   | 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced  |  | 12. Was Decedent Ever in U.S.<br>Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates:                            |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify:       |  | 14. Race - American Indian,<br>Black, White, etc.<br>Specify: <b>White</b> |   |   |  |
|   | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>4</b>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working<br>life. DO NOT use retired)<br><b>Accountant</b> |  | 16b. Kind of Business/Industry<br><b>Personal Accountant</b>   |  |  |   |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Solomon Bihovsky</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rebecca Sheinemann</b>   |  |  |   |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Virginia Bates/wife</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14949 Old Frederick Road, Woodbine, Maryland 21797</b> |  |  |   |   |  |
|   | 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)   |  | 20b. Place of Disposition (Name of<br>cemetery, crematory or other place)  |  | Data   |  | 20c. Location - City or Town, State  |   |   |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Ronald S. Wade, Director</b>   |  | 22. Name and Address of Facility<br><b>State Anatomy Board, 655 W. Baltimore Street<br/>Baltimore, Maryland 21201</b>                |  |  |  |  |   |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,<br>shock, or heart failure. List only one cause on each line.<br><b>a. Adenocarcinoma Lung</b><br>Due to (or as a consequence of):<br><b>b.</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |  |  |  |  |  |   | Approximate<br>Interval Between<br>Onset and Death<br><b>Months</b>   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown |  |
| 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No  |  |  |  |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No |   |  |
| 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No  |  | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |  |  |  |  |  |   |   |  |
| 27. Manner of Death<br><b>1</b> Natural <b>5</b> Pending investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide<br><b>4</b> Homicide   |  | 28a. Date of Injury<br>(Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>                  |  | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No |  | 28d. Describe how injury occurred   |   |  |
| 29a. Certifier<br>(Check only one)<br><b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>[Signature]</b>  |  |  |  |  |  |   | 29c. License number<br><b>D22856</b>  |  |
| 29d. Date signed (Month, Day, Year)<br><b>December 18, 1997</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JEFFREY I. LEVINE, 100 11055 Littlewood Rd, Columbia, MD 21044</b>                    |  |  |  |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>   |  | 32. Registrar's Signature<br><b>[Signature]</b>  |  |  |  |  |  |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39754

|   |  |  |   |  |   |                                |  |  |
|---|--|--|---|--|---|--------------------------------|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Howard CANTWELL</b>   |  |   |  | 2. Date of Death<br>Month <b>December</b> Day <b>23</b> Year <b>1997</b>  |                                | 3. Time of Death<br><b>3:55PM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Franklin Square Hospital Center</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Rosedale</b>   |                                | 4c. County of Death<br><b>Baltimore</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>216-05-5072</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>Dec 7 1914</b>                                       | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |
|   | Usual Residence of Decedent  |  |   |  |   |                                |  |  |
| To Be Completed by Funeral Director                                       | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Parkville</b>   |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|   | 10e. Street and Number<br><b>8800 Walker Blvd.</b>   |  |   |  | 10f. Zip Code<br><b>21234</b>   |                                | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2 yrs</b>  |  | College (1-4 or 5+) <b>+5 yrs</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>teacher</b>   |                                | 16b. Kind of Business/Industry<br><b>Baltimore County</b>                                      |  |
| To Be Completed by Physician/Medical Examiner                             | 17. Father's Name (First, Middle, Last)<br><b>Howard W. Cantwell Sr.</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anna K. Miller</b>  |                                |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Navilla M. Cantwell</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8800 Walker Blvd Apt. 212 Baltimore Md 21234</b>  |                                |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gardens of Faith</b>   |  | 20c. Location - City or Town, State<br><b>Rosedale Maryland</b>   |                                | 20d. Date<br><b>Dec 27 1997</b>  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Keisha S. Wells</b>  |  | 22. Name and Address of Facility<br><b>Evans Funeral Chapel<br/>8800 Harford Rd. Baltimore, Md 21234</b>  |  |   |                                |  |  |
| Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>e. <b>Hypoxemia</b><br>Due to (or as a consequence of):<br><br>b. <b>Hypotension</b><br>Due to (or as a consequence of):<br><br>c. <b>Septic shock</b><br>Due to (or as a consequence of):<br><br>d. <b>Neuropenia</b> |  |   |  |   |                                |  | Approximate Interval Between Onset and Death<br><br><b>6 minutes</b>   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>Myelodysplasia</b><br><br><b>Profound anemia</b>  |  |   |  |   |                                |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |   |                                |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |  |   |                                |  | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  |
|   | 28d. Describe how Injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                |  |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |                                |  | 29b. Signature and title of certifier<br><b>Deborah L. Gallo MD</b>  |
|   | 29c. License number<br><b>RD 2329</b>  |  |   |  |   |                                |  | 29d. Date signed (Month, Day, Year)<br><b>December 23, 1997</b>  |
| State Registrar   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Dr Deborah Gallo MD 9000 Franklin Square Drive Baltimore Maryland 21237</b>   |  |   |  |   |                                |  |  |
|   | 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>  |  |   |  | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>  |                                |  |  |



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State of Maryland / Department of Health and Mental Hygiene

9139755

Item: 2 Per Phy Film G-754 12-31-97RC

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |
|---|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>THOMAS FREDERICK CRUMP</b>   |  | 2. Date of Death<br>Month <b>12</b> Day <b>28</b> Year <b>97</b>  |  | 3. Time of Death<br><b>6:30 AM</b>   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>1119 N. BOND ST 21213</b>  |  | 4b. City, Town, or Location of Death<br><b>BALT.</b>  |  | 4c. County of Death<br><b>N/A</b>  |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-44-7777</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>51</b> Yrs.  | If Under 1 Year<br>Months Days                                 | If Under 24 Hrs.<br>Hours Min.   |
|   | 8. Date of Birth (Month, Day, Year)<br><b>8-28-1946</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>MD.</b>  |  |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |  |   |  |  |
|   | 10a. State<br><b>MD.</b>  | 10b. County<br><b>N/A</b>  | 10c. City, Town or Location<br><b>BALT</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
|   | 10e. Street and Number<br><b>1119 N. BOND ST</b>  |  | 10f. Zip Code<br><b>21213</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+)                     |  |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>MOVING + HAULING</b>  |  | 16b. Kind of Business/Industry<br><b>N/A.</b>   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>FREDERICK THOMAS CRUMP</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>FLORENCE VINCENT</b>  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>FREDA CRUMP (SISTER)</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8403 HORATIO RD RANDALLTOWN MD 21133</b>      |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MARYLAND NAT'L MEM. PK. 12/28 LAUREL MD.</b>                         |  | 20c. Location - City or Town, State  |
|   | 21. Signature of Funeral Service Licensee<br><b>[Signature]</b>   |  | 22. Name and Address of Facility<br><b>BETTS FUNERAL HOME BAL MD 21213</b>  |  |  |
| Physician<br>/Medical<br>Examiner   | 23a. Pertinent enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>OBSTRUCTIVE SLEEP APNEA</b><br>Due to (or as a consequence of):<br><br>b. <b>CONGESTIVE HEART FAILURE</b><br>Due to (or as a consequence of):<br><br>c. _____<br>Due to (or as a consequence of):<br><br>d. _____ |  |   |  | Approximate Interval Between Onset and Death<br><br><b>ONE YEAR</b><br><br><b>ONE YEAR</b>   |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |
| 26. Piece of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |   |  |  |
| 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |
| 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |  |  |
| 29b. Signature and title of certifier<br><b>[Signature]</b>   |   | 29c. License number<br><b>RES-000</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>DECEMBER 29 1997</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>FRED CHAN 600 NORTH WOLFE STREET BALTIMORE, MARYLAND 21287-8104</b>  |   |  |   |  |  |
| State Registrar   | 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>   |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10-15-1964

10-15-1964

10-15-1964

10-15-1964

10-15-1964

10-15-1964

10-15-1964

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39756

Physician  
/Medical  
Examiner

Funeral  
Director

|  |    |   |  |  |                                |   |  |   |    |                           |                                  |    |                                 |    |  |    |  |
|--|----|---|--|--|--------------------------------|---|--|---|----|---------------------------|----------------------------------|----|---------------------------------|----|--|----|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Dosey M. CARTER</b>   |    |   |  | 2. Date of Death<br>Month <b>12</b> Day <b>28</b> Year <b>97</b>   |                                | 3. Time of Death<br><b>9:35am</b>   |  |   |    |                           |                                  |    |                                 |    |  |    |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>5703 Pimlico Rd</b>   |    |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |                                | 4c. County of Death<br><b>NA</b>  |  |   |    |                           |                                  |    |                                 |    |  |    |  |
| 5. Social Security Number<br><b>09-18-8551</b>   |    | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (in yrs. last birthday)<br><b>73</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>4/21/24</b>                                       | 9. Birthplace (State or Foreign Country)<br><b>NY</b>  |   |    |                           |                                  |    |                                 |    |  |    |  |
| Usual Residence of Decedent  |    |   |  |  |                                |   |  |   |    |                           |                                  |    |                                 |    |  |    |  |
| 10a. State<br><b>MD</b>  |    | 10b. County<br><b>NA</b>  |  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |                                |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |    |                           |                                  |    |                                 |    |  |    |  |
| 10e. Street and Number<br><b>708 GLEN ALLEN DR.</b>  |    |   |  | 10f. Zip Code<br><b>21229</b>  |                                | 10g. Citizen of What Country?<br><b>USA</b>   |  |   |    |                           |                                  |    |                                 |    |  |    |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |    | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                     |  |   |    |                           |                                  |    |                                 |    |  |    |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (14 or 5+) <b>NA</b>  |    |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Clerk</b>  |                                | 16b. Kind of Business/Industry<br><b>Government</b>   |  |   |    |                           |                                  |    |                                 |    |  |    |  |
| 17. Father's Name (First, Middle, Last)<br><b>LOUIS GRIFFIN</b>  |    |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ADA GRIFFIN</b>  |                                |   |  |   |    |                           |                                  |    |                                 |    |  |    |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Michele Smith daughter</b>  |    |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>708 Glen Allen Dr BALTO. MD 21229</b>  |                                |   |  |   |    |                           |                                  |    |                                 |    |  |    |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |    | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arbutus Memorial</b>   |  | 20c. Location - City or Town, State<br><b>1-2-98 BALTIMORE, MD 21227</b>   |                                | 20d. Date   |  |   |    |                           |                                  |    |                                 |    |  |    |  |
| 21. Signature of Funeral Service Licensee<br>  |    |   |  | 22. Name and Address of Facility<br><b>ALBERT P. WYLLIE F/H PA</b><br><b>638 N. GILMORE ST. BALTO. MD 21217</b>  |                                |   |  |   |    |                           |                                  |    |                                 |    |  |    |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |    |   |  |  |                                |   |  |   |    |                           |                                  |    |                                 |    |  |    |  |
| <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td><b>Abdominal aneurysm</b></td> <td rowspan="4">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td><b>congestive heart failure</b></td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>   |    |   |  |  |                                |   |  | Immediate Cause (Final disease or condition resulting in death) | a. | <b>Abdominal aneurysm</b> | Due to (or as a consequence of): | b. | <b>congestive heart failure</b> | c. |  | d. |  |
| Immediate Cause (Final disease or condition resulting in death)  | a. | <b>Abdominal aneurysm</b>   | Due to (or as a consequence of):                 |  |                                |   |  |   |    |                           |                                  |    |                                 |    |  |    |  |
|  | b. | <b>congestive heart failure</b>   |  |  |                                |   |  |   |    |                           |                                  |    |                                 |    |  |    |  |
|  | c. |   |  |  |                                |   |  |   |    |                           |                                  |    |                                 |    |  |    |  |
|  | d. |   |  |  |                                |   |  |   |    |                           |                                  |    |                                 |    |  |    |  |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |    |   |  |  |                                |   |  |   |    |                           |                                  |    |                                 |    |  |    |  |
| 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |    |   |  |  |                                |   |  |   |    |                           |                                  |    |                                 |    |  |    |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |    |   |  |  |                                |   |  |   |    |                           |                                  |    |                                 |    |  |    |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |    |   |  |  |                                |   |  |   |    |                           |                                  |    |                                 |    |  |    |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |    | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |                                |   |  |   |    |                           |                                  |    |                                 |    |  |    |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |    | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |    |                           |                                  |    |                                 |    |  |    |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |    |   |  | 28d. Describe how injury occurred  |                                |   |  |   |    |                           |                                  |    |                                 |    |  |    |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |    |   |  |  |                                |   |  |   |    |                           |                                  |    |                                 |    |  |    |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |    |   |  |  |                                |   |  |   |    |                           |                                  |    |                                 |    |  |    |  |
| 29b. Signature and title of certifier<br><b>Anuradha Reddy MD</b>  |    |   |  | 29c. License number<br><b>046305</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>12/30/97</b>                                      |  |   |    |                           |                                  |    |                                 |    |  |    |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>ANURADHA REDDY 530 N HILTON Street Baltimore</b>  |    |   |  |  |                                |   |  |   |    |                           |                                  |    |                                 |    |  |    |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>  |    |   |  | 32. Registrar's Signature<br><b>Judith Davidson-Randall</b>  |                                |   |  |   |    |                           |                                  |    |                                 |    |  |    |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be checked within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39757

|   |  |   |   |  |   |   |  |   |
|---|--|---|---|--|---|---|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Calvin COX</b>  |   |   |  | 2. Date of Death<br>Month <b>December</b> Day <b>28</b> Year <b>1997</b>  |   | 3. Time of Death<br><b>5:55pm</b>  |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Northwest Medical Center</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>Randallstown</b>   |   | 4c. County of Death<br><b>Baltimore</b>  |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>239-78-3866</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>46</b> Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth<br>(Month, Day, Year)<br><b>August first 1951</b>                             | 9. Birthplace (State or Foreign Country)<br><b>N.C.</b>   |
|   | Usual Residence of Decedent  |   |   |  |   |   |  |   |
| To Be Completed by Funeral Director   | 10a. State<br><b>Md.</b>   | 10b. County<br><b>Baltimore</b>   |   | 10c. City, Town or Location<br><b>Randallstown</b>   |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
|   | 10e. Street and Number<br><b>8404 Downey Dale Drive</b>  |   |   |  | 10f. Zip Code<br><b>21133</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |   |
|   | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>1+</b> College (1-4or 5+)   |   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Truck Driver/ Minister</b>      |   |   | 16b. Kind of Business/Industry<br><b>Joseph Hock Co.</b>                                       |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>Calvin Cox SR.</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Maggie Thompson</b>   |   |  |   |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Sherri Cox wife</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8404 Downey Dale Drive Baltimore, Md. 21133</b>   |   |  |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arbutus Memorial Park</b>  |   | Date<br><b>Jan 2</b>   | 20c. Location - City or Town, State<br><b>Baltimore, Md.</b>  |
|   | 21. Signature of Funeral Service Licenses<br>  |   |   |  | 22. Name and Address of Facility<br><b>Nutter Funeral Homes, Inc.<br/>2501 Gwynns Falls PKWY Baltimore, Md. 21216</b>   |   |  |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>a. <b>Lung cancer</b><br>Due to (or as a consequence of):<br>b. <b>Human immunodeficiency virus</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |   |   |  | Approximate Interval Between Onset and Death<br><b>months</b><br><b>months</b>  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |   |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |   |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. Date of injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br>   |   | 29c. License number<br><b>D46263</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>December 28th 1997</b>                            |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>AYMAN YOUSSEI MD 5401 OLD COURT ROAD RANDALLSTOWN, MD 21133</b>  |  |   |   |  |   |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>   |  | 32. Registrar's Signature<br>   |   |  |   |   |  |   |

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760  
10



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39758

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EASLINE E. COLLINS

2. Date of Death

Month Day Year  
DECEMBER 25, 1997

3. Time of Death

12: P.M.

4a. Facility Name (If not institution, give street and number)

3302 W. FRANKLIN STREET (HOME)

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

219-40-8370

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
NOV 30, 1907

9. Birthplace (State or Foreign Country)

S. CAROLINA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3302 W. FRANKLIN STREET

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Navar Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: AFRO.AMERICAN

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HEALTH CARE PROVIDER

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

CHARLES BROWN SR.

18. Mother's Name (First, Middle, Maiden Surname)

MORIAH BROWN

19a. Informant's Name/Relationship (Type, Print)

LORANZER BETHEA

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1224 W. LANVALE STREET, BALTIMORE, MARYLAND 21217

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

ARBUTUS MEMORIAL PARK

Date

12/30/97 ARBUTUS, MARYLAND

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ESTEP BROTHERS FUNERAL HOME, P.A.

1300 EUTAW PLACE, BALTIMORE, MARYLAND 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

SEPSIS

a. Due to (or as a consequence of):

DECUBITUS ULCER

b. Due to (or as a consequence of):

MULTINFARCT DEMENTIA

c. Due to (or as a consequence of):

HYPERTENSION

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1 Day

1 Month

2 YEARS

20 YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accidental 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29e. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D30182

29d. Date signed (Month, Day, Year)

DECEMBER 25, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

WILLIAM RUSSELL 3421 BEDFORD AVE BALTIMORE MD 21227

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

EASLINE COLLINS



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item: 7 Per FH Film G-754 12-31-97RC

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Josephine Cannizzaro

2. Date of Death

Month 12 Day 26 Year 97

3. Time of Death

8:30 pm

4e. Facility Name (If not Institution, give street and number)

Stella Maris

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

219-14-2192

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95 94 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 19, 1902

9. Birthplace (State or Foreign Country)

Italy

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Timonium

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2300 Dulaney Valley Road

10f. Zip Code

21093

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

3

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Clothing

17. Father's Name (First, Middle, Last)

Francesco Cimolo

18. Mother's Name (First, Middle, Maiden Surname)

Rosa Cimino

19a. Informant's Name/Relationship (Type, Print)

Frank Cannizzaro, Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3013 Suffolk Lane, Fallston, MD 21047

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Loudon Park Mausoleum

Date

12/29/97

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Anthony S. Dr. Muro

22. Name and Address of Facility

Loudon Park Funeral Home

3620 Wilkens Avenue, Baltimore, MD 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. DEMENTIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Malignant Lymphoma

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Edwards

29c. License number

DU4128

29d. Date signed (Month, Day, Year)

December 26, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PENELOPE EDWARDS M.D.

2300 Dulaney Valley Road

Timonium, MD 21093

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

J. Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39760

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

KATHLYN CARLIN

2. Date of Death

Month Day Year  
12 28 97

3. Time of Death

10:45 A.M.

4e. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

506-05-5555

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 26, 1917

9. Birthplace (State or Foreign Country)

Nebraska

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Crownsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1004 Wallace Road

10f. Zip Code

21032

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

F.B.I.

17. Father's Name (First, Middle, Last)

Albert Ellis Harr

18. Mother's Name (First, Middle, Maiden Surname)

Philimena Kline

19a. Informant's Name/Relationship (Type, Print)

Mary C. Welday- Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

389 Yorkshire Lane, Riva, MD 21140

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Our Lady of the Fields

Date

12/31

20c. Location - City or Town, State

Millersville, MD

21. Signature of Funeral Service Licensee

Bates J. ...

22. Name and Address of Facility

Hardesty Funeral Home, P.A.

12 Ridgely Ave. Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIOPULMONARY FAILURE

Approximate Interval Between Onset and Death

3 DAYS

Due to (or as a consequence of):

b. DILATED CARDIOMYOPATHY

YEARS

Due to (or as a consequence of):

c. PNEUMONIA

WEEKS

Due to (or as a consequence of):

d. CHRONIC OBSTRUCTIVE PULM. DS.

YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

BRONCHIECTASIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28e. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Bates J. ...

29c. License number

023-142

29d. Date signed (Month, Day, Year)

12/29/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J.D. KRIMINS, M.D. 900 WESTGATE, RD.

ANNAPOLIS, MD 21401

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

John Harrison ...

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1911

1912

1913

1914

1915

1916

1917

1918

1919

1920

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39761

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ETHEL M. CULP

2. Date of Death

Month Day Year  
DECEMBER 21 97

3. Time of Death

4:00 PM

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

217-01-5400

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
MARCH 14, 1904

9. Birthplace (State or Foreign Country)

INDIANA

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6709 KINCHELOE AVENUE

10f. Zip Code

21207

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

UNKNOWN

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

SEAMSTRESS

16b. Kind of Business/Industry

SEWING FACTORY

17. Father's Name (First, Middle, Last)

FREDERICK BOARDMAN

18. Mother's Name (First, Middle, Maiden Surname)

MINNIE LEMMON

19a. Informant's Name/Relationship (Type, Print)

AUDREY C. SPEAR (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9802 MILLWICK DRIVE - ELLICOTT CITY, MD 21042

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

LORRAINE PARK CEMETERY

Date

12/24/97

20c. Location - City or Town, State

BALITMORE

21. Signature of Funeral Service Licenses

22. Name and Address of Facility

HUBBARD FUNERAL HOME INC.

4107 WILKENS AVENUE-BALTIMORE, MD 21229

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

DAY/S

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PNEUMONIA

RENAL FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D 43462

29d. Date signed (Month, Day, Year)

DECEMBER 21 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K. S. RAO, M.D.

NORTHWEST HOSPITAL CENTER

RANDALLSTOWN, MD

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 97 39762

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

G. RODERICK CHEESEMAN

2. Date of Death

Month Day Year  
DEC. 18 1997

3. Time of Death

3:25 AM

4a. Facility Name (if not institution, give street and number)

COLTON VILLA NURSING CENTER

4b. City, Town, or Location of Death

HAGERSTOWN

4c. County of Death

WASHINGTON

Funeral  
Director

5. Social Security Number

234-01-8223

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
AUG. 29, 1910

9. Birthplace (State or Foreign Country)

WEST VIRGINIA

Usual Residence of Decedent

10a. State

WV

10b. County

BERKELEY

10c. City, Town or Location

MARTINSBURG

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1000 N. HIGH STREET

10f. Zip Code

25401

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
5+16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

OWNER/OPERATOR

16b. Kind of Business/Industry

CHEESEMAN CONSTRUCTION

17. Father's Name (First, Middle, Last)

GEORGE CHEESEMAN

18. Mother's Name (First, Middle, Maiden Surname)

GRACE DUNHAM

19a. Informant's Name/Relationship (Type, Print)

ELAINE MAUCK / FRIEND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1000 N. HIGH STREET, MARTINSBURG, WV 25401

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

ROSEDALE CEMETERY

Date

12/22

20c. Location - City or Town, State

MARTINSBURG, WV

21. Signature of Funeral Service Licensee

Charles M. Brown

22. Name and Address of Facility

BROWN FUNERAL HOME, 327 W. KING STREET  
PO BOX 821, MARTINSBURG, WV 2540223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. ACUTE BRONCHO PNEUMONIA

2 DAYS

Due to (or as a consequence of):

b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

MANY YEARS

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death). Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

CARCINOMA OF PROSTATE

SENILE DEMENTIA

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☒ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural  
☐ Accident  
☐ Suicide  
☐ Homicide☐ Pending  
Investigation  
☐ Could not be  
determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
injury28c. Injury et  
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DR. EDSON MOODY, 1190 MT. AETNA RD., HAGERSTOWN, MD 21740

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

John Davidson

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39763

James Laurence Crowther

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician / Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |  |  |                                |  |  |
|--|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>JAMES LAURENCE CROWTHER</b>   |  |   |  | 2. Date of Death<br>Month <b>Dec</b> Day <b>21</b> Year <b>1997</b>  |                                | 3. Time of Death<br><b>10:50A</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>FAHRNEY KEEDY HOME</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>BOONSBORO</b>   |                                | 4c. County of Death<br><b>WASHINGTON</b>   |  |
| 5. Social Security Number<br><b>234-01-9908</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>JAN. 23, 1907</b>                                    |  |
| 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |  |   |  |  |                                |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>WASHINGTON</b>  |  | 10c. City, Town or Location<br><b>BOONSBORO</b>  |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>8507 MAPLEVILLE RD.</b>   |  |   |  | 10f. Zip Code<br><b>21713-1844</b>   |                                | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b><br>College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>MANAGER</b>   |  | 16b. Kind of Business/Industry<br><b>JOHN W. BISHOP CO. &amp; CLAMONT FARMS</b>  |                                |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>GEORGE R. CROWTHER</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Sumama)<br><b>MOSS REYNOLDS</b>   |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>ANN G. CRAMER/DAUGHTER</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8 GRAY DRIVE, PASADENA, MD 21122</b>   |                                |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ROSEDALE CEMETERY</b>  |  | Data<br><b>12/23</b>   |                                | 20c. Location - City or Town, State<br><b>MARTINSBURG, WV</b>                                  |  |
| 21. Signature of Funeral Service Licensee<br><b>Charles M. Brown</b>   |  |   |  | 22. Name and Address of Facility<br><b>BROWN FUNERAL HOME, 327 W. KING ST. PO BOX 821, MARTINSBURG, WV 25402</b>   |                                |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Cerebrovascular disease</b><br>Due to (or as a consequence of):<br>b. <b>Atherosclerotic heart disease</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |                                |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Parkinson's Disease</b>   |  |   |  |  |                                |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |   |  |  |                                |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |                                |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |                                |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |                                |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28d. Describe how Injury occurred  |                                |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |                                |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |                                |  |  |
| 29b. Signature and title of certifier<br><b>[Signature]</b>  |  |   |  | 29c. License number<br><b>030584</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>12/21/97</b>   |  |
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print)<br><b>Laurence Greenspan, MD; 130 W. High St.; Hancock, Md. 21750</b>   |  |   |  |  |                                |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>  |  |   |  | 32. Registrar's Signature<br><b>[Signature]</b>  |                                |  |  |

ADDITIONAL INFORMATION

ADDITIONAL INFORMATION

FAHNNY KEEP HOME

WASHINGTON

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 39764

|  |  |  |  |   |   |  |  |  |  |
|--|--|--|--|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Edward Theodore Dorba                        |  |  |   | 2. Date of Death<br>Month Day Year<br>December 29, 1997 |  | 3. Time of Death<br>6:40 PM                          |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Eastpoint Nursing Home |  |  |   | 4b. City, Town, or Location of Death<br>Dundalk         |  | 4c. County of Death<br>Baltimore                     |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>217-09-8760   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br>86 Yrs.               |  | 8. Date of Birth (Month, Day, Year)<br>June 10, 1911 |  |  |
|  | 9. Birthplace (State or Foreign Country)<br>Pennsylvania                                 |  | 10a. State<br>Maryland   |   | 10b. County<br>Baltimore                                |  | 10c. City, Town or Location<br>Dundalk               |  |  |
| Usual Residence of Decedent  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br>1046 Old North Point Road   |   | 10f. Zip Code<br>21224   |  | 10g. Citizen of What Country?<br>United States                   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 6 Years   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Painter   |  | 16b. Kind of Business/Industry<br>Painting Company  |   |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Stanislaus Dorbach  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Josephine Jaworski   |   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Helen Dorba Daughter   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3213 Hamilton Ave. Baltimore, Maryland 21224   |   |  |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Hilltop Service Corp.  |  | 20c. Location - City or Town, State<br>Towson, MD   |   |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Robert M. Heming</i>   |  | 22. Name and Address of Facility<br>Duda-Ruck Funeral Home of Dundalk, Inc.<br>7922 Wise Ave. Dundalk, Maryland 21222  |  |   |   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><i>Cancer of the tongue</i><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause (disease or injury that initiated events resulting in death) Last<br><i>Cancer of the Larynx</i><br>Due to (or as a consequence of): |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | Approximate Interval Between Onset and Death<br><i>&gt; 6 mo</i> |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Cancer of The Larynx</i>  |  |  |  |   |   |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |   | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br>M   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br><i>Melito M. Torres</i>   |  | 29c. License number<br>11150  |   | 29d. Date signed (Month, Day, Year)<br>12/30/97  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>MELITO M. TORRES, MD 441 S. ELLWOOD AVE, BALTO, MD 21224   |  | 31. Date filed (Month, Day, Year)<br>DEC 31 1997   |  | 32. Registrar's Signature<br><i>Julia Davidson-Pondsee</i>  |   |  |  |  |  |

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

To Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39765

|  |   |                          |  |  |  |  |  |   |
|--|---|--------------------------|--|--|--|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>JAMES H. DAVIS</b>   |                          |  |  | 2. Date of Death<br>Month <b>12</b> Day <b>28</b> Year <b>97</b>   |  | 3. Time of Death<br><b>6:23 PM</b>                             |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>BON SECOURS HOSPITAL</b>   |                          |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>NA</b>                               |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>226-16-3820</b>   |                          | 6. Sex<br><b>1 M 2 F</b>   | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.                             | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                         | 8. Date of Birth (Month, Day, Year)<br><b>10/17/10</b>         | 9. Birthplace (State or Foreign Country)<br><b>NC</b> |
|  | Usual Residence of Decedent   |                          |  |  |  |  |  |   |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>   | 10b. County<br><b>NA</b> | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  |  | 10d. Inside City Limits<br><b>1 Yes 2 No</b>           |  |   |
|  | 10e. Street and Number<br><b>538 N. CARROLLTON AVE.</b>   |                          |  | 10f. Zip Code<br><b>21223</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>            |  |   |
|  | 11. Marital Status<br><b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>   |                          | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 Yes 2 No</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><b>1 Yes 2 No</b>  |  | 14. Race - American Indian, Black, White, etc.<br><b>Black</b> |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br><b>6th</b>   |                          | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Fireman Helper</b> |  | 16b. Kind of Business/Industry<br><b>Industry Soap</b>   |  |  |   |
| To Be Completed by Physician/Medical Examiner  | 17. Father's Name (First, Middle, Last)<br><b>Willis Davis</b>  |                          |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Alice Davis</b>  |  |  |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Shirley Burrell daughter</b>   |                          |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1702 Ramblewood Rd BALTO. MD 21239</b> |  |  |   |
|  | 20a. Method of Disposition<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>   |                          | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>WESTERN STAR</b>                                      |  | 20c. Location - City or Town, State<br><b>13-98 BALTIMORE, MD</b>  |  |  |   |
|  | 21. Signature of Funeral Service Licensee<br>   |                          |  |  | 22. Name and Address of Facility<br><b>ALBERT P. WYLLIE F/H PA 638 N. GILMORE ST. BALTO. MD 21217</b>                                      |  |  |   |
| Physician<br>/Medical<br>Examiner  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. |                          |  |  |  |  |  |   |
|  | Immediate Cause (Final disease or condition resulting in death)<br><b>a. Arteriosclerotic Cardiovascular Disease</b>  |                          |  |  |  |  |  |   |
|  | Due to (or as a consequence of):<br><b>b. Esophageal Carcinoma</b>  |                          |  |  |  |  |  |   |
|  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>c. Due to (or as a consequence of):</b>  |                          |  |  |  |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |                          |  |  |  |  |  |   |
| 23b. Did tobacco use contribute to the cause of death?<br><b>1 Yes 2 No 3 Probably 4 Unknown</b>   |   |                          |  |  |  |  |  |   |
| 24a. Was an autopsy performed?<br><b>1 Yes 2 No</b>  |   |                          |  |  |  |  |  |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 Yes 2 No</b>   |   |                          |  |  |  |  |  |   |
| 25. Was case referred to medical examiner?<br><b>1 Yes 2 No</b>  |   |                          |  |  |  |  |  |   |
| 26. Place of Death (Check only one)<br>Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>   |   |                          |  |  |  |  |  |   |
| 27. Manner of Death<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>  |   |                          |  | 28a. Date of Injury (Month, Day, Year)                                       |  |  |  | 28b. Time of Injury<br><b>M</b>                       |
| 28c. Injury at Work?<br><b>1 Yes 2 No</b>  |   |                          |  | 28d. Describe how injury occurred  |  |  |  |   |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |   |                          |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |  |   |
| 29a. Certifier (Check only one)<br><b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b> |   |                          |  |  |  |  |  |   |
| 29b. Signature and title of certifier<br><b>Robert R. Cruz M-D</b>   |   |                          |  | 29c. License number<br><b>030355</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>12/28/97</b> |  |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>ROSITA R. CRUZ M-D BON SECOURS HOSPITAL</b>   |   |                          |  |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>  |   |                          |  | 32. Registrar's Signature<br>  |  |  |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 97 39766

|   |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>James A. Day Jr.</b>  |  |   |  | 2. Date of Death<br>Month <b>December</b> Day <b>17</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>10 10 pm</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>LIBERTY MEDICAL CENTER</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>N/A</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>214-30-0903</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>64</b> Yrs.   |  | 8. Date of Birth<br>Month <b>August</b> Day <b>14</b> Year <b>1933</b>           |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>CHARLES, CO.</b>  |  | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>BALTIMORE</b>  |  | 10c. City, Town or Location<br><b>BALTIMORE</b>                                  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>1338 N. MOUNT STREET</b>   |  | 10f. Zip Code<br><b>21217</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                                      |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:    |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>AFRO.AMERICAN</b>  |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>STEEL WORKER</b>  |  | 16b. Kind of Business/Industry<br><b>UNITED STATES STEELCORP</b>   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>JAMES DAY SR.</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARGARET DAY</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>ANNETTA DAY WIFE</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1338 N. MOUNT STREET, BALTIMORE, MARYLAND 21217</b>  |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MT. ZION CEMETERY</b>  |  | 20c. Location - City or Town, State<br><b>12/23/97 LANSDOWNE, MD.</b>  |  | 20d. Date  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>ESTEP BROTHERS FUNERAL SERVICE, P.A.<br/>1300 EUTAW PLACE, BALTIMORE, MARYLAND 21217</b>  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Hepatic Encephalopathy</b><br>Due to (or as a consequence of):<br><b>b. Liver Cancer</b><br>Due to (or as a consequence of):<br><b>c. Renal insufficiency</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |   |  | Approximate Interval Between Onset and Death<br><b>unknown</b><br><b>unknown</b><br><b>unknown</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Anemia</b>  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>B3583</b>  |  |
| To Be Completed by Physician/Medical Examiner | 29d. Date signed (Month, Day, Year)<br><b>December 17, 1997</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Hafiz Zrebaet LMC. 2600 Liberty Heights Ave Balt. Md 21215</b>   |  |  |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>  |  | 32. Registrar's Signature<br>   |  |  |  |  |  |

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

39767

|  |  |   |   |   |  |  |  |  |
|--|--|---|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>FRANCES BERTHA EMERSON</b>                            |   |   |   | 2. Date of Death<br>Month Day Year<br><b>DECEMBER 29, 1997</b>   |  | 3. Time of Death<br><b>12:43 AM</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Saint Joseph Medical Center</b> |   |   |   | 4b. City, Town, or Location of Death<br><b>Towson</b>  |  | 4c. County of Death<br><b>Baltimore</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>214-22-9999</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>April 2, 1928</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |
|  | Usual Residence of Decedent  |   |   |   |  |  |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Baltimore</b>   |   | 10c. City, Town or Location<br><b>Baltimore</b>   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>2211 Ellen Avenue</b>   |  |   |   | 10f. Zip Code<br><b>21234</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b> |  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Peter Klimczak</b>   |  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Theresa Unknown</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Judith Emerson/Daughter</b>   |  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2211 Ellen Avenue Baltimore, MD 21234</b>  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Bulaney Valley Mem. Grdn.</b>  |   |  | 20c. Location - City or Town, State<br><b>12/31/97 Timonium, Maryland</b>  |  |  |
| 21. Signature of Funeral Home Licensed<br>   |  |   | 22. Name and Address of Facility<br><b>Ruck Towson Funeral Home, Inc.<br/>1050 York Road Towson, Maryland 21204</b>                               |   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death) <b>SEPSIS</b><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of): |  |   |   |   |  |  |  | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ENDSTAGE RENAL DISEASE</b>  |  |   |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |
|  |  |   |   |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br>   |   | 29c. License number<br><b>D30263</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>12-29-97</b>   |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>FRANCIS KHOO, M.D. 7620 YORK ROAD TOWSON, MARYLAND 21204</b>  |  |   |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>  |  | 32. Registrar's Signature<br>   |   |   |  |  |  |  |

MEMORANDUM FOR THE DIRECTOR  
FROM: [illegible]  
SUBJECT: [illegible]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39768

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |   |  |  |  |                                |   |   |  |                                       |  |  |
|---|---|--|--|--|--------------------------------|---|---|--|---------------------------------------|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>JAN EVANS</b>                                    |  |  |  |                                |   | 2. Date of Death<br>Month Day Year<br><b>DECEMBER 25, 1997</b>        |  | 3. Time of Death<br><b>10:15 P.M.</b> |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>LIBERTY MEDICAL CENTER</b> |  |  |  |                                |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>              |  | 4c. County of Death<br><b>N/A</b>     |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>217-66-8035</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>42</b> Yrs. | 8. Under 1 Year<br>Months Days   | 9. Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>4-9-1955</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>BALTO. MD</b>   |                                       |  |  |
|   | Usual Residence of Decedent   |  |  |  |                                |   |   |  |                                       | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>N/A</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>  |                                |   |   | 10d. Inside City Limits  |                                       |  |  |
| 10e. Street and Number<br><b>4102 EVANS Chapel Rd</b>   |   |  |  | 10f. Zip Code<br><b>21211</b>  |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |   |  |                                       |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLK</b> |  |                                       |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11th</b> College (1-4 or 5+)  |   |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Auto Mechanic</b>  |                                |   | 16b. Kind of Business/Industry<br><b>self Employed</b>                |  |                                       |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>James G. Evans</b>  |   |  |  |  |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Johnson</b>  |   |  |                                       |  |  |
| 19a. Informant's Name/Relationship (Type, Print) (Mother)<br><b>Mrs. Mary A. Evans</b>  |   |  |  |  |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4102 Evans Chapel Rd Baltimore Md 21211</b> |   |  |                                       |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Woodlawn Cem</b>  |  | 20c. Date<br><b>12/26/97</b>   |                                | 20d. Location - City or Town, State<br><b>Baltimore Co. Md</b>  |   |  |                                       |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Joseph L. Russ</b>  |   |  |  | 22. Name and Address of Facility<br><b>Joseph L. Russ Funeral Home<br/>2202 W. North Ave. Baltimore Md 21216</b>   |                                |   |   |  |                                       |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Cirrhosis Liver and Hepatitis</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d.</b> |   |  |  |  |                                |   |   |  |                                       | Approximate Interval Between Onset and Death   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |  |  |                                |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |                                       |  |  |
|   |   |  |  |  |                                |   |   | 24e. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |                                       |  |  |
|   |   |  |  |  |                                |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |                                       |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |                                |   |   |  |                                       |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>  |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how Injury occurred  |                                       |  |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |                                |   |   |  |                                       |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   | 29b. Signature and title of certifier<br><b>Thodore M. King</b>  |  |  |                                | 29c. License number<br><b>O.C.M.E.</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>DECEMBER 26, 1997</b>  |                                       |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Thodore M. King 111 Penn Street, Baltimore, Maryland 21201</b>   |   |  |  |  |                                |   |   |  |                                       |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>   |   | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>   |  |  |                                |   |   |  |                                       |  |  |

17. 2. 1901

City of New York

Received of the City of New York  
the sum of \$100.00  
for the purchase of the  
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City of New York

AM  
KENNETH  
EVANS

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39769

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Kenneth L. Evans

2. Date of Death  
Month Day Year

DECEMBER 27, 1997

3. Time of Death

3:03 P

4a. Facility Name (If not institution, give street and number)

JOPPA ROAD EAST &amp; LAKESIDE DR.

4b. City, Town, or Location of Death

N/A

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

047-44-5363

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

39 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

JUNE 14, 1958

9. Birthplace (State or Foreign Country)

Connecticut

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13 Melanie Court

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Engineer

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

James Evans

18. Mother's Name (First, Middle, Maiden Surname)

Charlotte Eisen

19a. Informant's Name/Relationship (Type, Print)

James Evans/father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

65 Glenbrook Road Apt. 3E Stanford, CT 06902

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metro Crematory, Inc.

Date

12/29/97

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Dawn F. McDonald

22. Name and Address of Facility

Cremation Society of Maryland, Inc.  
299 Frederick Road Baltimore, MD 2122823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Multiple Injuries and Compression

Due to (or as a consequence of):

Asphyxia

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

c.

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) PEDESTRIAN

27. Manner of Death

1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)

12/27/97

28b. Time of  
Injury

4:46 M

28c. Injury at  
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Pedestrian struck by vehicle

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

Street

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

Joppa Rd. East &amp; Lakeside Rd

29e. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. Aaron Locke MD

29c. License number

OCME

29d. Date signed (Month, Day, Year)

DECEMBER 28, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Aaron Locke MD 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 39770

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Debra Ann Frazier

2. Date of Death  
Month Day Year  
DECEMBER 26, 19973. Time of Death  
5:14 PFuneral  
Director

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS HOSPITAL ER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

213-84-7315

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

35 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Mar 6, 1962

9. Birthplace (State or Foreign Country)

Md

Usual Residence of Decedent

10a. State

Md

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

723 North Caroline Street

10f. Zip Code

21213

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12th

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Data Entry Operator

16b. Kind of Business/Industry

City Gov't

17. Father's Name (First, Middle, Last)

Clifford Williams

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Frazier

19a. Informant's Name/Relationship (Type, Print)

Evelyn Whye (Aunt)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4714 Alhambra Avenue Baltimore, Md 21212

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Pleasant Rest Cem 12/30/97 Towson, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Caple Funeral Service  
5502 Winner Avenue Baltimore, Md 2121523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

COCAINE INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

EPIDERMOID TUMOR INVOLVING THE THIRD VENTRICLE REGION OF THE BRAIN

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 3 ☐ Suicide  
4 ☐ Homicide 6 ☒ Could not be determined28a. Date of Injury  
(Month, Day, Year)

found 12/26/97

28b. Time of  
injury

4:30

P.

M

28c. Injury at  
Work?1 ☐ Yes 2 ☒ No

28d. Describe how Injury occurred

Subject ingested drugs

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)  
found in house28f. Location (Street and Number or Rural Route Number,  
City or Town, State) 1428 Federal St.  
Baltimore, MD.29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

OCME

29d. Date signed (Month, Day, Year)

DECEMBER 27, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39771

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

GRACE E. FLACK

2. Date of Death

Month Day Year  
DEC. 25 1997

3. Time of Death

8:30 AM

4a. Facility Name (If not institution, give street and number)

HANFORD MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

HAYRE DE GRACE

4c. County of Death

HANFORD

5. Social Security Number

213-26-1099

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 8, 1909

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

HANFORD

10c. City, Town or Location

BELAIR

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1708 REDFIELD RD.

10f. Zip Code

21015

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

CHARLES LAMM

18. Mother's Name (First, Middle, Maiden Surname)

LOUISE PESSAGNO

19a. Informant's Name/Relationship (Type, Print)

JESSIE BOBLITS (Nephew in Law)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

812 EASTRIDGE RD. ABBINGTON 21009 MD.

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

New CATHEDRAL CEM

Date

12/29/97

20c. Location - City or Town, State

BMD. MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DELLA NOLE & SONS FUNERAL HOME  
322 S. HIGH ST. BMD. 21202 MD.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

coronary artery disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

acute renal failure  
Alzheimer's disease w/ dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D28339

29d. Date signed (Month, Day, Year)

December 25, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LINDA FREILICH 101 E. Wheel Road Bel Air MD 21015

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760, Baltimore, MD 21268-0760



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39772

Physician  
/Medical  
ExaminerFuneral  
Director

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Holly Fox</b>   |  |  |  | 2. Date of Death<br>Month <b>December</b> Day <b>23</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>23:37</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Johns Hopkins Hospital</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>   |  | 4c. County of Death<br><b>N/A</b>  |  |
| 5. Social Security Number<br><b>091-64-1451</b>  |  | 6. Sex<br><b>1</b> M <b>2</b> F  |  | 7. Age (In yrs. last birthday)<br><b>28</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>APR. 6, 1969</b>                             |  |
| 9. Birthplace (State or Foreign Country)<br><b>New York</b>  |  | 10a. State<br><b>Pa.</b>   |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Schwenksville</b>                                    |  |
| 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No  |  | 10e. Street and Number<br><b>115 Village Drive</b>   |  | 10f. Zip Code<br><b>19473</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2+</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Dental Hygienist</b>   |  | 16b. Kind of Business/Industry<br><b>Oaks Family Dental</b>   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Lawrence Kennedy</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Phyllis Galarneau</b>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Joseph B. Fox - husband</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>115 Village Dr., Schwenksville, Pa. 19473</b> |  |  |  |
| 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. John's Cemetery</b>   |  | Date<br><b>12/29/97</b>   |  | 20c. Location - City or Town, State<br><b>Troy, New York</b>                           |  |
| 21. Signature of Funeral Service Licensee<br>  |  |  |  | 22. Name and Address of Facility<br><b>Gary L. Kaufman Funeral Home at Meadowridge MP<br/>7250 Washington Blvd., Elkridge, Md. 21075</b>          |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)  |  | a. <b>Cerebral Infarctions</b>   |  |   |  | 2 days   |  |
|  |  | Due to (or as a consequence of):   |  |   |  |  |  |
|  |  | b. <b>Subarachnoid Hemorrhage</b>  |  |   |  | 7 days   |  |
|  |  | Due to (or as a consequence of):   |  |   |  |  |  |
|  |  | c. <b>Ruptured intracerebral aneurysm</b>  |  |   |  | 7 days   |  |
|  |  | Due to (or as a consequence of):   |  |   |  |  |  |
|  |  | d.   |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown  |  |  |  |   |  |  |  |
| 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No   |  |  |  |
| 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No   |  | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |  |   |  |  |  |
| 27. Manner of Death<br><b>1</b> Natural <b>5</b> Pending investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide   |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No                                       |  |
|  |  | 28d. Describe how injury occurred  |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  |
|  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |
| 29a. Certifier (Check only one)<br><b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |  |   |  |  |  |
| 29b. Signature and title of certifier<br> <b>MD</b>   |  |  |  | 29c. License number<br><b>RES-000</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>December 24, 1997</b>                        |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Lauren R. Moo, MD Johns Hopkins Hospital</b>  |  |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>  |  |  |  | 32. Registrar's Signature<br>                                  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39773

|   |   |  |   |  |   |  |   |  |  |  |  |
|---|---|--|---|--|---|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>CLARKE J. FITZPATRICK, JR.</b>                             |  |   |  | 2. Date of Death<br>Month Day Year<br><b>DECEMBER 27 1997</b>   |  |   |  | 3. Time of Death<br><b>9:35 AM</b>   |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>GREATER BALTIMORE MEDICAL CENTER</b> |  |   |  | 4b. City, Town, or Location of Death<br><b>TOWSON</b>   |  |   |  | 4c. County of Death<br><b>BALTIMORE</b>  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-18-1601</b>   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>72</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>MAR. 26, 1925</b> |  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>                                      |  |  |
|   | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>BALTIMORE</b>   |  | 10c. City, Town or Location<br><b>CATONSVILLE</b>   |  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 10e. Street and Number<br><b>3 SEMINOLE AVENUE</b>  |   |  |   |  | 10f. Zip Code<br><b>21228</b>   |  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No <b>WWII</b><br>If Yes, Give Year or Dates: |  |   | 13. Was Decedent of Hispanic Origin? (Specify Year or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                          |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>4</b>  |   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>GRAPHIC ART SALES PERSON</b>  |  |   | 16b. Kind of Business/Industry<br><b>GRAPHIC ARTS</b>  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>CLARKE JOSEPH FITZPATRICK, SR.</b>  |   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>LINDA KATHLEEN CALLAHAN</b>   |  |   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>CLARKE J. FITZPATRICK, III, SON</b>  |   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9213 FURROW AVENUE, ELLICOTT CITY, MARYLAND 21042</b>   |  |   |  |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>BALTIMORE/WASHINGTON CREMATORY</b>   |  |   | 20c. Location - City or Town, State<br><b>12/30/97 LAUREL, MARYLAND</b>  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |   |  |   |  | 22. Name and Address of Facility<br><b>WITZKE FUNERAL HOMES, INC.<br/>1630 EDMONDSON AVENUE, CATONSVILLE, MD 21228</b>  |  |   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>LUNG CANCER</b><br>Due to (or as a consequence of):<br><b>HYPERTENSIA</b><br>Due to (or as a consequence of):<br><b>SMOKING.</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |  |   |  |   |  |   |  |  | Approximate Interval Between Onset and Death |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |   |  |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |
|   |   |  |   |  |   |  |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |
|   |   |  |   |  |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   |  |   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>                             |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No             |  |  |
|   |   |  |   |  | 28d. Describe how injury occurred   |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |
|   |   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |  |   |  |   |  |   |  |  |  |  |
| 29b. Signature and title of certifier<br><br><b>Dr. J. H. Balaramanian</b>   |   |  |   |  | 29c. License number<br><b>1752279</b>   |  |   | 29d. Date signed (Month, Day, Year)<br><b>12/27/97</b>   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jouran H. Balaramanian Suite 3853 N Charles Street Baltimore MD 21204</b>  |   |  |   |  |   |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>   |   |  |   |  | 32. Registrar's Signature<br>  |  |   |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the final-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39774

Amended #10b, 10c, 10e, 10f per FH G755 1/14/98 EW

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MILDRED I. FITZWATER

2. Date of Death

Month Day Year  
DECEMBER 25, 1997

3. Time of Death

12:45 A.M.

4a. Facility Name (If not institution, give street and number)

AUGSBURG LUTHERAN HOME

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

215-24-2598

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JUNE 25, 1914

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

~~CARROLL~~ Baltimore

10c. City, Town or Location

~~MT. AIRY~~ Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

~~6605 WIND RIDGE ROAD~~ 38 Ridge Road

10f. Zip Code

~~21771~~ 21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1 YR

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

ACCOUNT CLERK

16b. Kind of Business/Industry

SOCIAL SECURITY

17. Father's Name (First, Middle, Last)

EVERETT PATE BURNS

18. Mother's Name (First, Middle, Maiden Surname)

MARIE HEDDINGER

19a. Informant's Name/Relationship (Type, Print)

ALETA BOWLING (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6605 WIND RIDGE ROAD - MT. AIRY, MD 21771

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

LAKEVIEW CEMETERY

Date

12/29/97 BALTIMORE

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HUBBARD FUNERAL HOME INC.

4107 WILKENS AVE - BALTIMORE, MD 21229

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. metastatic colon cancer  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.   
Due to (or as a consequence of):c.   
Due to (or as a consequence of):d.   
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

7 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D37573

29d. Date signed (Month, Day, Year)

Dec 26, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jef Zbell MD 7220 Park Heights Ave Baltimore MD 21208

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's signature

State  
Registrar

Mildred Fitzwater  
 Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be recorded within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39775

|  |  |  |   |   |  |  |  |  |   |   |                  |  |  |  |    |    |
|--|--|--|---|---|--|--|--|--|---|---|------------------|--|--|--|----|----|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>JOHN CARL FRANK</b>                                   |  |   |   | 2. Date of Death<br>Month Day Year<br><b>DECEMBER 29, 1997</b>   |  |  |  | 3. Time of Death<br><b>9:23 PM</b>                          |   |                  |  |  |  |    |    |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Saint Joseph Medical Center</b> |  |   |   | 4b. City, Town, or Location of Death<br><b>Towson</b>  |  |  |  | 4c. County of Death<br><b>Baltimore</b>                     |   |                  |  |  |  |    |    |
| Funeral<br>Director  | 5. Social Security Number<br><b>213-28-4490</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (in yrs. last birthday)<br><b>67</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>APR. 9, 1930</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |   |                  |  |  |  |    |    |
|  | Usual Residence of Decedent  |  |   |   |  |  |  |  |   |   |                  |  |  |  |    |    |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Baltimore</b>  |   | 10c. City, Town or Location<br><b>Towson</b>  |  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |                  |  |  |  |    |    |
| 10e. Street and Number<br><b>7700 York Road</b>  |  |  |   | 10f. Zip Code<br><b>21204</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |   |   |                  |  |  |  |    |    |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |   |                  |  |  |  |    |    |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Exterminator</b>  |  |  | 16b. Kind of Business/Industry<br><b>Pest Control</b>      |  |   |   |                  |  |  |  |    |    |
| 17. Father's Name (First, Middle, Last)<br><b>Unk.</b>   |  |  |   |   |  | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Unk.</b>   |  |  |   |   |                  |  |  |  |    |    |
| 19a. Informant's Name/Relationship (Type, Print) <b>step-</b><br><b>Deborah Lynn Mitchell/ daughter</b>  |  |  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1202 Windsail Road Apt. G Baltimore, MD 21221-4621</b> |  |  |   |   |                  |  |  |  |    |    |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc.</b>  |  | Date<br><b>12/30/97</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>  |   |   |                  |  |  |  |    |    |
| 21. Signature of Funeral Service Licensee<br><b>David F. McDonald</b>  |  |  |   | 22. Name and Address of Facility<br><b>Cremation Society of Maryland, Inc.</b><br><b>299 Frederick Road Baltimore, MD 21228</b>   |  |  |  |  |   |   |                  |  |  |  |    |    |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |   |   |  |  |  |  |   |   |                  |  |  |  |    |    |
| <table border="0"> <tr> <td rowspan="4">                 Immediate Cause (Final disease or condition resulting in death)<br/><br/>                 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last             </td> <td>a. <b>SEPSIS</b></td> <td rowspan="4">                 Due to (or as a consequence of):<br/><br/>                 Due to (or as a consequence of):<br/><br/>                 Due to (or as a consequence of):<br/><br/>                 Due to (or as a consequence of):             </td> <td rowspan="4">                 Approximate Interval Between Onset and Death<br/><br/>                 DAYS<br/><br/>                 DAYS             </td> </tr> <tr> <td>b. <b>COLONIC OBSTRUCTION AND GANGRENE</b></td> </tr> <tr> <td>c.</td> </tr> <tr> <td>d.</td> </tr> </table> |  |  |   |   |  |  |  |  |   | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <b>SEPSIS</b> | Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): | Approximate Interval Between Onset and Death<br><br>DAYS<br><br>DAYS | b. <b>COLONIC OBSTRUCTION AND GANGRENE</b> | c. | d. |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | a. <b>SEPSIS</b>   | Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): | Approximate Interval Between Onset and Death<br><br>DAYS<br><br>DAYS  |   |  |  |  |  |   |   |                  |  |  |  |    |    |
|  | b. <b>COLONIC OBSTRUCTION AND GANGRENE</b>   |  |   |   |  |  |  |  |   |   |                  |  |  |  |    |    |
|  | c.   |  |   |   |  |  |  |  |   |   |                  |  |  |  |    |    |
|  | d.   |  |   |   |  |  |  |  |   |   |                  |  |  |  |    |    |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |   |                  |  |  |  |    |    |
|  |  |  |   |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |                  |  |  |  |    |    |
|  |  |  |   |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |                  |  |  |  |    |    |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |   |   |                  |  |  |  |    |    |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |                  |  |  |  |    |    |
|  |  |  |   | 28d. Describe how injury occurred   |  |  |  |  |   |   |                  |  |  |  |    |    |
|  |  |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |  |   |   |                  |  |  |  |    |    |
|  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |   |   |                  |  |  |  |    |    |
| 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |  |   |   |  |  |  |  |   |   |                  |  |  |  |    |    |
| 29b. Signature and title of certifier<br><b>Timothy Low, M.D.</b>  |  |  |   | 29c. License number<br><b>D24034</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>12/30/97</b>   |  |  |   |   |                  |  |  |  |    |    |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>TIMOTHY LOW, M.D. 7620 YORK ROAD TOWSON, MARYLAND 21204</b>   |  |  |   |   |  |  |  |  |   |   |                  |  |  |  |    |    |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>  |  |  |   | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>  |  |  |  |  |   |   |                  |  |  |  |    |    |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,  
Baltimore, Maryland 21268-0760

State  
Registrar

THE  
UNITED STATES  
DEPARTMENT OF THE ARMY  
WASHINGTON, D. C.  
OFFICE OF THE CHIEF OF STAFF  
MEMORANDUM FOR THE CHIEF OF STAFF  
SUBJECT: [Illegible]  
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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39776

|  |  |                               |   |  |  |  |   |  |
|--|--|-------------------------------|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Robert Saint John Ghirardi</b>  |                               |   |  | 2. Date of Death<br>Month <b>December</b> Day <b>29</b> , Year <b>1997</b>   |  | 3. Time of Death<br><b>4:38 A. M.</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Franklin Square Hospital</b>  |                               |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>Baltimore</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-48-2135</b>  |                               | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>51</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>May 9, 1946</b>                                   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Connecticut</b>   |                               | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                               | 10e. Street and Number<br><b>3714 Seneca Garden Road</b>  |  | 10f. Zip Code<br><b>21220</b>  |  | 10g. Citizen of What Country?<br><b>U. S. A.</b>  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |                               | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>  |                               | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Assembly Worker</b>   |  | 16b. Kind of Business/Industry<br><b>Car Manufacturer</b>  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Austin Richard Ghirardi</b>  |                               |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Evelyn Neary</b>   |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Marian R. Ghirardi (Wife)</b>   |                               |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3714 Seneca Garden Road, Baltimore, Maryland 21220</b>                                   |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |                               | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holly Hill Mem. Gardens</b>  |  | 20c. Date<br><b>1/2/98</b>   |  | 20d. Location - City or Town, State<br><b>Baltimore, Maryland</b>                           |  |
|  | 21. Signature of Funeral Service Licensee<br>  |                               | 22. Name and Address of Facility<br><b>Schimunek Funeral Home of Bel Air Inc.<br/>610 W. Macphail Road, Bel Air, Maryland 21014</b>   |  |  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Small Cell Lung Cancer</b><br>Due to (or as a consequence of):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |                               |   |  |  |  |   |  |
|  | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |                               |   |  |  |  |   |  |
|  | 23c. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |                               |   |  |  |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                               |   |  |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |                               |   |  |  |  |   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                               | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |                               | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | 28d. Describe how injury occurred  |                               | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |                               |   |  |  |  |   |  |
| State Registrar  | 29b. Signature and title of certifier<br>  |                               |   |  | 29c. License number<br><b>D15546</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>Dec. 30, 1997</b>                                 |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Charles Padgett MD, 5601 Loch Raven Blvd, Baltimore, MD 21239</b>   |                               |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>  |  | 32. Registrar's Signature<br> |   |  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23c show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 23a per State of Maryland, Department of Health and Mental Hygiene  
COURT ORDER, 8/18/06/16/2011 and  
Certificate of Death

Reg. No.

97 39777

|                                     |  |  |   |   |  |  |  |
|-------------------------------------|--|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>IDA E. GRANTHAM</b>   |  |   |   | 2. Date of Death<br>Month Day Year<br><b>Dec 29 97</b>   |  | 3. Time of Death<br><b>0930</b>  |
|                                     | 4a. Facility Name (If not institution, give street and number)<br><b>ANNE ARUNDEL GEN. HOSP.</b>   |  |   |   | 4b. City, Town, or Location of Death<br><b>ANNAPOLIS</b>   |  | 4c. County of Death<br><b>AA</b>   |
| Funeral<br>Director                 | 5. Social Security Number<br><b>171-10-6209</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>APR 12, 1917</b>                                     | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                      |
|                                     | Usual Residence of Decedent  |  |   |   |  |  |  |
| To Be Completed by Funeral Director | 10a. State<br><b>MD</b>  | 10b. County<br><b>Anne Arundel</b>   | 10c. City, Town or Location<br><b>Crofton</b>   |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|                                     | 10e. Street and Number<br><b>1682 Fallowfield Court</b>  |  |   | 10f. Zip Code<br><b>21114</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|                                     | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>          |
|                                     | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                     |   | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |  |
|                                     | 17. Father's Name (First, Middle, Last)<br><b>Alphonso Louis Dunham, III</b>   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Bessie Florence Johnson</b>  |  |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br><b>Leslie B. Kupres/daughter</b>   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1682 Fallowfield Ct. Crofton, MD 21114</b>   |  |  |
|                                     | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc. 12/31/97</b>                                   |   | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>  |  |  |
|                                     | 21. Signature of Funeral Service Licensee<br><b>Edward A. Gregorchik</b>   |  |   |   | 22. Name and Address of Facility<br><b>Cremation Society of Maryland, Inc.<br/>299 Frederick Rd. Baltimore, MD 21228</b>   |  |  |
|                                     | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Congestive Heart Failure</b><br>e. <del>Acute Respiratory Failure</del> Minutes<br>Due to (or as a consequence of): <b>Chronic Obstructive Pulmonary</b><br>b. <del>Chronic Asthma</del> Disease<br>Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |  |  |
|                                     | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |  |  |
| Physician<br>/Medical<br>Examiner   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |   |  |  |  |
|                                     | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |  |
|                                     | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |   |  |  |  |
|                                     | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |   |  |  |  |
|                                     | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
|                                     | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |   | 28d. Describe how injury occurred  |  |  |
|                                     | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |  |  |  |
|                                     | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.  |  |   |   |  |  |  |
|                                     | 29b. Signature and title of certifier<br><b>William P. Jones, MD Deputy</b>  |  | 29c. License number<br><b>D 06054</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>12/29/97</b>   |  |  |
|                                     | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>William P. Jones, MD 695 America 21035</b>  |  |   |   |  |  |  |
| State<br>Registrar                  | 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>  |  | 32. Registrar's Signature<br><b>Luka Davidson-Rendell</b>   |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

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AS 14-34-62

TO: Mr. J. Edgar Hoover  
FROM: Mr. [illegible]  
SUBJECT: [illegible]

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Amended #1,4c per PHY G754 12/31/97 EW

97 39778

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) Annette Irene Gutowski

2. Date of Death  
Month Day Year  
December 30, 1997  
3. Time of Death  
12:46 AM

4a. Facility Name (If not institution, give street and number)

Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore N7A

Funeral  
Director

5. Social Security Number

214-20-4479

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
OCT 19, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7901 Charlesmont Road

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

William Harry Stout

18. Mother's Name (First, Middle, Maiden Surname)

Anna Bell Eller

19a. Informant's Name/Relationship (Type, Print)

Wayne M. Barry/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

414 Cornwall Street Baltimore, MD 21224

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metro Crematory, Inc.

Date

12/31/97

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service licensee

Edward A. Gregorchik

22. Name and Address of Facility

Cremation Society of MD, Inc.

299 Frederick Rd Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

one week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Richard Saha MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

December 30, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Richard Saha, MD, Tower 110, 600 N. WOLFE STREET, BALTIMORE, MD 21207

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39779

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLES H. GORDON

2. Date of Death  
Month Day Year  
December 28 1997

3. Time of Death  
6:30 AM

4a. Facility Name (If not institution, give street and number)

Deaton University of Maryland Medicine Baltimore

4b. City, Town, or Location of Death

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

212 05 8597

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
12/31/15

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

303 CHERRYHILL ROAD

10f. Zip Code

21225

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates: 1/43 2/46

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: AFR. AMERICAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SYRUP DEPT.

16b. Kind of Business/Industry

COCA COLA CO.

17. Father's Name (First, Middle, Last)

HARVEY E. GORDON

18. Mother's Name (First, Middle, Maiden Surname)

ALBERTA HARRIETT

19a. Informant's Name/Relationship (Type, Print)

BERNICE H. GORDON WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

303 CHERRYHILL RD. BALTO. MD. 21225

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CROWNSVILLE V.A.

Date

12/31/97

20c. Location - City or Town, State

CROWNSVILLE, MD.

21. Signature of Funeral Service Licensee

Carl A. Jolley

22. Name and Address of Facility

ESTEP BROTHERS FUNERAL HOME P.A.  
1300 EUTAW PL. BALTO. MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

PNEUMONIA

a. Due to (or as a consequence of):

COLON CARCINOMA

b. Due to (or as a consequence of):

METASTATIC COLON CARCINOMA (LIVER)

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

7 Days

Oct 1997

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEIZURE DISORDER

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

26. Place of Death (Check only one)

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James P. Flynn MD

29c. License number

201346

29d. Date signed (Month, Day, Year)

Dec 29 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAMES FLYNN MD, DEATON SPECIALTY HOSPITAL/HOME 611 S. CHARLES ST BALTIMORE MD 21230

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

Charles Henry Gordon

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39780

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WALTER Edward Grempier

2. Date of Death

December 29, 1997

3. Time of Death

9:25 AM

4a. Facility Name (If not institution, give street and number)

418 HARWOOD ROAD

4b. City, Town, or Location of Death

CATONSVILLE

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

218-14-6775

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JAN. 7, 1921

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

CATONSVILLE

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

418 HARWOOD ROAD

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☒ Yes ☐ No  
If Yes, Give  
Year or Dates:

WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
WHITE15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

SHEET METAL WORKER

16b. Kind of Business/Industry

HEATING DUCTS

17. Father's Name (First, Middle, Last)

WALTER E. GREMPER, SR.

18. Mother's Name (First, Middle, Maiden Surname)

MAMIE DANKMEYER

19a. Informant's Name/Relationship (Type, Print)

LILLIAN E. GREMPER, WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

418 HARWOOD ROAD, CATONSVILLE, MARYLAND 21228

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

LORRAINE PARK CEMETERY

Date

1/2/98

20c. Location - City or Town, State

WOODLAWN, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

WITZKE FUNERAL HOMES, INC.

1630 EDMONDSON AVENUE, CATONSVILLE, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

YEARS

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☒ Yes ☐ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
Investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☒ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D11171

29d. Date signed (Month, Day, Year)

December 29, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

E. P. Williamson II 405 Frederick Ave CATONSVILLE 21228  
MARYLAND

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39781

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ANNA

GERNER

2. Date of Death  
Month Day Year

December 24, 1997

2:35 am

4a. Facility Name (If not institution, give street and number)

RIVERVIEW NURSING HOME

4b. City, Town, or Location of Death

ESSEX

BALTIMORE

5. Social Security Number

494-16-0515

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

102 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

MAY 20, 1895

9. Birthplace (State or Foreign Country)

POLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

ESSEX

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

1 EASTERN BOULEVARD

10f. Zip Code

21221

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

CHAIM

LOHEIT

18. Mother's Name (First, Middle, Maiden Surname)

SHEINDEL

KOLTAN

19a. Informant's Name/Relationship (Type, Print)

ERIKA GREENBLUM / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3619 GLENGYLE AVE. #8B BALTIMORE, MD 21215

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. HEBRON CEMETERY

Date

12/26/97

20c. Location - City or Town, State

FLUSHING, NEW YORK

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Sol Levinson & Bros., Inc.  
8900 Reisterstown Road Pikesville, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Alzheimer's Dementia*

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 years

b. *Hypertension*

Due to (or as a consequence of):

4 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

N. Deshpande MD

29c. License number

D46082

29d. Date signed (Month, Day, Year)

12/24/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NEETA DESHPANDE, M.D.  
1 EASTERN BLVD. BALTIMORE, MD 21221

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39782

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

DORA

GITTLEMAN

2. Date of Death

Month Day Year  
December 28, 1997

3. Time of Death

3:05 P.M.

4a. Facility Name (If not institution, give street and number)

Fox Chase Rehabilitation &amp; Nursing Center

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

164-10-6989

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

101

8. Date of Birth

If Under 1 Year If Under 24 Hrs.  
Months Days Hours Min.8. Date of Birth  
(Month, Day, Year)

Sept. 1, 1896

9. Birthplace (State or Foreign Country)

Russia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Chevy Chase

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2100 Connecticut Avenue, Apt. 1211

10f. Zip Code

20815

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever In U.S.  
Armed Forces?1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify:

White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

9th Grade

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Chaim Borden

18. Mother's Name (First, Middle, Maiden Surname)

Tsivia (Unknown)

19a. Informant's Name/Relationship (Type, Print)

Evelyn Viener, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2100 Connecticut Avenue, Apt. 1211  
Chevy Chase, Maryland 20815

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Roosevelt Memorial Park

12/30/1997

20c. Location - City or Town, State

Trevose, Pennsylvania

21. Signature of Funeral Service Licensee

m00544

22. Name and Address of Facility

STEIN HEBREW MEMORIAL FUNERAL HOME, INC.

232 CARROLL STREET, NW, WASHINGTON, DC 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

ARRHYTHMIA

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)29b. Signature and title of certifier  
29c. License number  
29d. Date signed (Month, Day, Year)

T. S. Anthony

D 50300

DECEMBER 29, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Thomas J. Anthony, M.D., 11119 Rockville Pike, Rockville, Maryland 20852

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

John Anderson

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39783

|   |   |  |   |  |   |                          |  |  |  |   |   |  |
|---|---|--|---|--|---|--------------------------|--|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Estil E. Greene   |  |   |  | 2. Date of Death<br>Month Day Year<br>Dec. 24 97  |                          |  |  | 3. Time of Death<br>3:00pm   |   |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Mariner Nursing Home  |  |   |  | 4b. City, Town, or Location of Death<br>BelAir  |                          |  |  | 4c. County of Death<br>Harford   |   |   |  |
| Funeral<br>Director   | 5. Social Security Number<br>219-36-0203  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>85 Yrs.   |                          | 8. Date of Birth (Month, Day, Year)<br>April 2, 1912           |  | 9. Birthplace (State or Foreign Country)<br>North Carolina   |   |   |  |
|   | Usual Residence of Decedent   |  |   |  |   |                          |  |  |  |   |   |  |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland  |  | 10b. County<br>Harford  |  | 10c. City, Town or Location<br>Fallston   |                          |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |   |  |
|   | 10e. Street and Number<br>1108 Peach Tree Road  |  |   |  | 10f. Zip Code<br>21047  |                          | 10g. Citizen of What Country?<br>U.S.A.                        |  |  |   |   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                          |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |  |   |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12th. College (1-4 or 5+) n/a  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Farmer   |                          |  | 16b. Kind of Business/Industry<br>Self Employed                                      |  |   |   |  |
|   | 17. Father's Name (First, Middle, Last)<br>Linney Greene  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Jennie Michael   |                          |  |  |  |   |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Ethel W. Greene (Wife)  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1108 Peach Tree Road Fallston, Md. 21047   |                          |  |  |  |   |   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Upper Cross Roads Baptist Ch.   |  | 20c. Date<br>12/27/97   |                          | 20d. Location - City or Town, State<br>Baldwin, Maryland 21013 |  |  |   |   |  |
|   | 21. Signature of Funeral Service Licensee<br>E. F. Lassahn  |  |   |  | 22. Name and Address of Facility<br>E.F. Lassahn Funeral Home<br>11750 Belair Road Kingsville, Maryland 21087   |                          |  |  |  |   |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. <u>Alzheimers Dementia</u><br>Due to (or as a consequence of):<br>b. _____<br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |   |                          |  |  |  |   | Approximate interval Between Onset and Death<br>years   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Pernicious anemia</u><br><u>Bladder cancer</u>   |  |   |  |   |                          |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   |  |   |                          |  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |   |  |   | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br>M |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how Injury occurred   |   |  |
|   |   |  |   | 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify) |   |                          |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |  |   |   |  |
| 29a. Certifier (Check only one)<br>2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |  |   |  |   |                          |  |  |  |   |   |  |
| 29b. Signature and title of certifier<br>P. Dubyoski  |   |  |   | 29c. License number<br>D29227  |   |                          |  | 29d. Date signed (Month, Day, Year)<br>12/24/97                                      |  |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>PATRICIA DUBYOSKI C150. Moreland Rd Bel Air MD 21014  |   |  |   |  |   |                          |  |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br>DEC 31 1997  |   |  |   | 32. Registrar's Signature<br>John Davidson-Randall                                     |   |                          |  |  |  |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Physician  
/Medical  
Examiner

State  
Registrar

ESTIL E. GREENE

RA

6



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item : 8 Per MEO Film G-754 12-31-97RC

## Certificate of Death

Reg. No.

97 39784

|  |  |  |                                 |   |  |   |   |  |
|--|--|--|---------------------------------|---|--|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Frederick GOEB</b>  |  |                                 |   | 2. Date of Death<br>Month <b>December</b> Day <b>22</b> Year <b>1997</b> |   | 3. Time of Death<br><b>7:20 PM</b>                              |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Franklin Square Hospital Center</b> |  |                                 |   | 4b. City, Town, or Location of Death<br><b>Rosedale</b>                  |   | 4c. County of Death<br><b>Baltimore</b>                         |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>216-05-8223</b>  |  | 6. Sex<br><b>1</b> M <b>2</b> F |   | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.                         |   | 8. Date of Birth (Month, Day, Year)<br><b>December 22, 1909</b> |  |
|  | 9. Birthplace (State or Foreign)<br><b>Maryland</b>  |  | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Baltimore City</b>                                     |   | 10c. City, Town or Location<br><b>Baltimore</b>                 |  |
| 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No  |  | 10e. Street and Number<br><b>1046 Old North Point Road</b>   |                                 | 10f. Zip Code<br><b>21224</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |   |  |
| 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates: <b>1927-1933</b>  |                                 | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify:     |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>3</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>unknown</b>  |                                 | 16b. Kind of Business/Industry<br><b>unknown</b>  |  |   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>George Goeb</b>  |  |  |                                 | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Louisa Engelhart</b>  |  |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary L. Nawrocki/daughter</b>   |  |  |                                 | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3805 D. Memory Lane, Abingdon, Maryland 21009</b> |  |   |   |  |
| 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)   |                                 | Date  |  | 20c. Location - City or Town, State   |   |  |
| 21. Signature of Funeral Service Licensee<br><b>Ronald S. Wade, Director</b>   |  |  |                                 | 22. Name and Address of Facility<br><b>State Anatomy Board, 655 W. Baltimore Street<br/>Baltimore, Maryland 21201</b>                                 |  |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Infected decubitus ulcer</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |  |                                 | Approximate Interval Between Onset and Death<br><b>1 month</b>  |  |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic obstructive pulmonary disease</b><br><b>Congestive heart failure, benign prostatic hypertrophy</b><br><b>Atrial fibrillation</b>  |  |  |                                 |   |  | 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown |   |  |
| 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No  |                                 |   |  |   |   |  |
| 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No   |  | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |                                 |   |  |   |   |  |
| 27. Manner of Death<br><b>1</b> Natural <b>2</b> Accident <b>3</b> Suicide <b>4</b> Homicide<br><b>5</b> Pending Investigation <b>6</b> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)   |                                 | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No  |   |  |
| 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |                                 | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |  |
| 29a. Certifier (Check only one)<br><b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br><b>Kristin A. Pena MD</b>   |                                 | 29c. License number<br><b>RD2323</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>December 22, 1997</b>   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr Kristin Pena MD 9000 Franklin Square Drive Baltimore Maryland 21237</b>  |  |  |                                 |   |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>  |  |  |                                 |   |  |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

39785

|  |   |   |  |                               |  |  |   |                                   |  |   |   |   |  |   |                                     |   |                                     |  |  |  |  |                                       |  |                          |  |  |  |                                   |  |  |  |  |  |  |  |  |  |  |  |
|--|---|---|--|-------------------------------|--|--|---|-----------------------------------|--|---|---|---|--|---|-------------------------------------|---|-------------------------------------|--|--|--|--|---------------------------------------|--|--------------------------|--|--|--|-----------------------------------|--|--|--|--|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Francis Hugh Gardner, III   |   |  |                               | 2. Date of Death<br>Month Day Year<br>December 17, 1997  |  |   |                                   | 3. Time of Death<br>6:00 AM  |   |   |   |  |   |                                     |   |                                     |  |  |  |  |                                       |  |                          |  |  |  |                                   |  |  |  |  |  |  |  |  |  |  |  |
|  | 4e. Facility Name (If not institution, give street and number)<br>912 Pentwood Court  |   |  |                               | 4b. City, Town, or Location of Death<br>Bel Air  |  |   |                                   | 4c. County of Death<br>Harford   |   |   |   |  |   |                                     |   |                                     |  |  |  |  |                                       |  |                          |  |  |  |                                   |  |  |  |  |  |  |  |  |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>216-40-2454  |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |                               | 7. Age (In yrs. last birthday)<br>55 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Sept. 23, 1942 |                                   | 9. Birthplace (State or Foreign Country)<br>Maryland   |   |   |   |  |   |                                     |   |                                     |  |  |  |  |                                       |  |                          |  |  |  |                                   |  |  |  |  |  |  |  |  |  |  |  |
|  | Usual Residence of Decedent   |   |  |                               |  |  |   |                                   |  |   |   |   |  |   |                                     |   |                                     |  |  |  |  |                                       |  |                          |  |  |  |                                   |  |  |  |  |  |  |  |  |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>Maryland  |   | 10b. County<br>Harford   |                               | 10c. City, Town or Location<br>Bel Air   |  |   |                                   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |   |   |  |   |                                     |   |                                     |  |  |  |  |                                       |  |                          |  |  |  |                                   |  |  |  |  |  |  |  |  |  |  |  |
|  | 10e. Street and Number<br>912 Pentwood Court  |   |  |                               | 10f. Zip Code<br>21014   |  |   |                                   | 10g. Citizen of What Country?<br>U.S.A.  |   |   |   |  |   |                                     |   |                                     |  |  |  |  |                                       |  |                          |  |  |  |                                   |  |  |  |  |  |  |  |  |  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |                               | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   |                                   | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |   |   |   |  |   |                                     |   |                                     |  |  |  |  |                                       |  |                          |  |  |  |                                   |  |  |  |  |  |  |  |  |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0   |   |  |                               | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Currier   |  |   |                                   | 16b. Kind of Business/Industry<br>Commercial Airline   |   |   |   |  |   |                                     |   |                                     |  |  |  |  |                                       |  |                          |  |  |  |                                   |  |  |  |  |  |  |  |  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Francis Hugh Gardner, Jr.  |   |  |                               | 18. Mother's Name (First, Middle, Maiden Surname)<br>Myrtle Elizabeth Butts  |  |   |                                   |  |   |   |   |  |   |                                     |   |                                     |  |  |  |  |                                       |  |                          |  |  |  |                                   |  |  |  |  |  |  |  |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Norman E. Sauter/son-in-law   |   |  |                               | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>912 Pentwood Court, Bel Air, Maryland 21014   |  |   |                                   |  |   |   |   |  |   |                                     |   |                                     |  |  |  |  |                                       |  |                          |  |  |  |                                   |  |  |  |  |  |  |  |  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)   |                               | Date   |  | 20c. Location - City or Town, State                   |                                   |  |   |   |   |  |   |                                     |   |                                     |  |  |  |  |                                       |  |                          |  |  |  |                                   |  |  |  |  |  |  |  |  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>Ronald S. Wade, Director   |   |  |                               | 22. Name and Address of Facility<br>State Anatomy Board, 655 W. Baltimore Street<br>Baltimore, Maryland 21201  |  |   |                                   |  |   |   |   |  |   |                                     |   |                                     |  |  |  |  |                                       |  |                          |  |  |  |                                   |  |  |  |  |  |  |  |  |  |  |  |
|  | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |  |                               |  |  |   |                                   |  |   |   |   |  |   |                                     |   |                                     |  |  |  |  |                                       |  |                          |  |  |  |                                   |  |  |  |  |  |  |  |  |  |  |  |
|  | <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td rowspan="4">}</td> <td>a. Chronic Obstructive Pulmonary Disease</td> <td rowspan="4">10 years</td> </tr> <tr> <td>b. Due to (or as a consequence of):</td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> </tr> </table> |   |  |                               |  |  |   |                                   |  |   | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | }   | a. Chronic Obstructive Pulmonary Disease | 10 years  | b. Due to (or as a consequence of): | c. Due to (or as a consequence of):   | d. Due to (or as a consequence of): |  |  |  |  |                                       |  |                          |  |  |  |                                   |  |  |  |  |  |  |  |  |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | }   | a. Chronic Obstructive Pulmonary Disease  | 10 years   |                               |  |  |   |                                   |  |   |   |   |  |   |                                     |   |                                     |  |  |  |  |                                       |  |                          |  |  |  |                                   |  |  |  |  |  |  |  |  |  |  |  |
|  |   | b. Due to (or as a consequence of):   |  |                               |  |  |   |                                   |  |   |   |   |  |   |                                     |   |                                     |  |  |  |  |                                       |  |                          |  |  |  |                                   |  |  |  |  |  |  |  |  |  |  |  |
|  |   | c. Due to (or as a consequence of):   |  |                               |  |  |   |                                   |  |   |   |   |  |   |                                     |   |                                     |  |  |  |  |                                       |  |                          |  |  |  |                                   |  |  |  |  |  |  |  |  |  |  |  |
|  |   | d. Due to (or as a consequence of):   |  |                               |  |  |   |                                   |  |   |   |   |  |   |                                     |   |                                     |  |  |  |  |                                       |  |                          |  |  |  |                                   |  |  |  |  |  |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |                               |  |  |   |                                   |  |   |   |   |  |   |                                     |   |                                     |  |  |  |  |                                       |  |                          |  |  |  |                                   |  |  |  |  |  |  |  |  |  |  |  |
| <table border="0"> <tr> <td colspan="4">23b. Did tobacco use contribute to the cause of death?<br/>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</td> </tr> <tr> <td colspan="2">24a. Was an autopsy performed?<br/>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> <td colspan="2">24b. Were autopsy findings available prior to completion of cause of death?<br/>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> </tr> </table>   |   |   |  |                               |  |  |   |                                   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                     | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                     |  |  |  |  |                                       |  |                          |  |  |  |                                   |  |  |  |  |  |  |  |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |   |   |  |                               |  |  |   |                                   |  |   |   |   |  |   |                                     |   |                                     |  |  |  |  |                                       |  |                          |  |  |  |                                   |  |  |  |  |  |  |  |  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |                               |  |  |   |                                   |  |   |   |   |  |   |                                     |   |                                     |  |  |  |  |                                       |  |                          |  |  |  |                                   |  |  |  |  |  |  |  |  |  |  |  |
| <table border="0"> <tr> <td colspan="2">25. Was case referred to medical examiner?<br/>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> <td colspan="8">26. Place of Death (Check only one)<br/>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</td> </tr> <tr> <td colspan="2">27. Manner of Death<br/>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br/>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined</td> <td colspan="2">28a. Date of Injury (Month, Day Year)</td> <td colspan="2">28b. Time of Injury<br/>M</td> <td colspan="2">28c. Injury at Work?<br/>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> <td colspan="2">28d. Describe how injury occurred</td> </tr> <tr> <td colspan="2"></td> <td colspan="4">28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</td> <td colspan="4">28f. Location (Street and Number or Rural Route Number, City or Town, State)</td> </tr> </table> |   |   |  |                               |  |  |   |                                   |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |                                     |   |                                     |  |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year) |  | 28b. Time of Injury<br>M |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred |  |  |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                               |  |  |   |                                   |  |   |   |   |  |   |                                     |   |                                     |  |  |  |  |                                       |  |                          |  |  |  |                                   |  |  |  |  |  |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M      |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   | 28d. Describe how injury occurred |  |   |   |   |  |   |                                     |   |                                     |  |  |  |  |                                       |  |                          |  |  |  |                                   |  |  |  |  |  |  |  |  |  |  |  |
|  |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |                               |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |   |                                   |  |   |   |   |  |   |                                     |   |                                     |  |  |  |  |                                       |  |                          |  |  |  |                                   |  |  |  |  |  |  |  |  |  |  |  |
| <table border="0"> <tr> <td colspan="2">29a. Certifier (Check only one)<br/>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</td> <td colspan="2">29b. Signature and title of certifier<br/>JTA MD</td> <td colspan="2">29c. License number<br/>D34652</td> <td colspan="4">29d. Date signed (Month, Day, Year)<br/>December 18, 1997</td> </tr> </table>   |   |   |  |                               |  |  |   |                                   |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br>JTA MD   |  | 29c. License number<br>D34652   |                                     | 29d. Date signed (Month, Day, Year)<br>December 18, 1997  |                                     |  |  |  |  |                                       |  |                          |  |  |  |                                   |  |  |  |  |  |  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   | 29b. Signature and title of certifier<br>JTA MD   |  | 29c. License number<br>D34652 |  | 29d. Date signed (Month, Day, Year)<br>December 18, 1997                             |   |                                   |  |   |   |   |  |   |                                     |   |                                     |  |  |  |  |                                       |  |                          |  |  |  |                                   |  |  |  |  |  |  |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Scott Haswell 2 North Avenue, Bel Air Maryland 21014   |   |   |  |                               |  |  |   |                                   |  |   |   |   |  |   |                                     |   |                                     |  |  |  |  |                                       |  |                          |  |  |  |                                   |  |  |  |  |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>DEC 31 1997   |   |   |  |                               |  |  |   |                                   |  |   |   |   |  |   |                                     |   |                                     |  |  |  |  |                                       |  |                          |  |  |  |                                   |  |  |  |  |  |  |  |  |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Beulah Lee Gorsuch

2. Date of Death  
Month Day Year  
December 16, 19973. Time of Death  
5:20 p.m.

4a. Facility Name (If not institution, give street and number)

BROADMEAD

4b. City, Town, or Location of Death

Cockeysville

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

214-40-5802

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

93

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

11/12/04

9. Birthplace (State or Foreign  
Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Cockeysville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13801 York Road

10f. Zip Code

21030

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever In U.S.  
Armed Forces?1 ☐ Yes 2 ☒ NoIf Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Librarian Head

16b. Kind of Business/Industry

Library

17. Father's Name (First, Middle, Last)

Robert Lee Bledsoe

18. Mother's Name (First, Middle, Maiden Surname)

Beulah Evans

19a. Informant's Name/Relationship (Type, Print)

Frank M. Gorsuch, III/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2504 Dorval Road, Wilmington, Delaware 19810

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☒ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore Street  
Baltimore, Maryland 2120123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

2 weeks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD

Ischemic Heart Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
Investigation6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

► [Signature] MD

29c. License number

D22627

29d. Date signed (Month, Day, Year)

12/17/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

BROADMEAD 13801 YORK RD, Cockeysville MD 21030

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

Julia Davidson-Rendall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39787

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Arvie Holcomb

2. Date of Death

Month

Day

3. Time of Death

Year

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Funeral  
Director

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

424-72-1782

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

07/08/1923

9. Birthplace (State or Foreign Country)

AL

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

TOWSON

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7001 NORTH CHARLES STREET

10f. Zip Code

21204

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

2

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SEAMSTRESS

16b. Kind of Business/Industry

CLOTHING MANUFACTURING

17. Father's Name (First, Middle, Last)

WILLIAM REID CRABTREE

18. Mother's Name (First, Middle, Maiden Surname)

FLORENCE NOVELLA REYNOLDS

19a. Informant's Name/Relationship (Type, Print)

CAROLYN BLANKENSHIP/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

29778 HILLVIEW DRIVE MECHANICSVILLE, MD 20659

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HOLCOMB CEMETERY

Data

1/2/98

20c. Location - City or Town, State

FLAT ROCK, AL

21. Signature of Funeral Service Licensee

Phillips

22. Name and Address of Facility

STERLING ASHTON FUNERAL HOME, INC.

736 EDMONDSON AVE., BALTIMORE, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Coronary Occlusion

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

d. Chronic Obstructive Pulmonary Disease

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Charles F. O'Donnell MD

29c. License number

D-09383

29d. Date signed (Month, Day, Year)

December 28, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles F. O'Donnell MD - 111 Hamlet Hill Rd - Baltimore, Maryland 21210

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

John Davidson

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 39788

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John W Heiser Jr

2. Date of Death

Month

Day

Year

December 29 1997

3. Time of Death

1900

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

219-28-3889

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Nov. 21, 1934

9. Birthplace (State or Foreign Country)

Nebraska

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Fallston

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

800 Millwood Drive

10f. Zip Code

21047

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 Years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Self Employed/  
Builder/Developer

16b. Kind of Business/Industry

Homes

17. Father's Name (First, Middle, Last)

John William Heiser Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Betty Limes

19a. Informant's Name/Relationship (Type, Print)

Jean P. Heiser (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

800 Millwood Drive, Fallston, Maryland 21047

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bel Air Memorial Gardens 1/2/98

Date

20c. Location - City or Town, State

Bel Air, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Schimunek Funeral Home of Bel Air Inc.  
610 W. Macphail Road, Bel Air, Maryland 21014Physician  
/Medical  
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Severe Cardiac Dysfunction

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 months

18 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

None

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] Dr J Solga House Officer

29c. License number

RE 5-000

29d. Date signed (Month, Day, Year)

December 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Steven F. Solga Johns Hopkins Hospital 600 North Wolfe Street, Baltimore Maryland 21287

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39789

VALERIA  
HERRING

|  |   |                           |   |   |  |   |  |   |  |
|--|---|---------------------------|---|---|--|---|--|---|--|
| <b>Physician<br/>/Medical<br/>Examiner</b>   | 1. Decedent's Name (First, Middle, Last)<br><b>VALERIA MARIE HERRING</b>                                      |                           |   |   |  | 2. Date of Death<br>Month Day Year<br><b>DECEMBER 23, 1997</b>    |  | 3. Time of Death<br><b>5:05 P.M.</b>                                    |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>JOHNS HOPKINS BAYVIEW MEDICAL CENTER</b> |                           |   |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>          |  | 4c. County of Death<br><b>N/A</b>                                       |  |
| <b>Funeral<br/>Director</b>  | 5. Social Security Number<br><b>213-30-1846</b>   |                           | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>63</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                                    | 8. Date of Birth (Month, Day, Year)<br><b>APRIL 8, 1934</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>WEST VIRGINIA</b> |
|  | Usual Residence of Decedent   |                           |   |   |  |   |  |   |  |
| 10a. State<br><b>MARYLAND</b>  |   | 10b. County<br><b>N/A</b> |   | 10c. City, Town or Location<br><b>Baltimore</b>   |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |
| 10e. Street and Number<br><b>1156 ARMISTEAD WAY</b>  |   |                           |   |   | 10f. Zip Code<br><b>21205</b>  |   | 10g. Citizen of What Country?<br><b>U. S. A.</b>   |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th GRADE</b>   |   |                           |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>MANAGER</b> |  |   | 16b. Kind of Business/Industry<br><b>CONVENIENCE STORE</b>   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>RALPH MASON CARVER</b>   |   |                           |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>RUTH WILSON</b>  |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>CINDY YOST (DAUGHTER)</b>   |   |                           |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1129 STEIGER WAY, BALTIMORE, MARYLAND 21205</b>  |   |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |                           |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GREEN MOUNT CREMATORY</b>                      |  | 20c. Location - City or Town, State<br><b>BALTIMORE, MARYLAND</b> |  |   |  |
| 21. Signature of Funeral Service Licensee<br>  |   |                           |   |   | 22. Name and Address of Facility<br><b>SCHIMUNEK FUNERAL HOME INC.<br/>3331 BREHMS LANE, BALTIMORE, MARYLAND 21213</b>   |   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Atherosclerotic cardiovascular disease</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   |                           |   |   |  |   |  |   | Approximate Interval Between Onset and Death                     |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |                           |   |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |
|  |   |                           |   |   |  |   | 24a. Was an autopsy performed?<br><b>INSPECTION</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |
|  |   |                           |   |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |                           | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |  |   |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   |                           | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred                                |
|  |   |                           | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |                           | 29b. Signature and title of certifier<br>  |   |  | 29c. License number<br><b>O.C.M.E.</b>                            |  | 29d. Date signed (Month, Day, Year)<br><b>DECEMBER 24, 1997</b>         |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>MARYLAND N. KOSAR VIK 111 Penn Street, Baltimore, Maryland 21201</b>  |   |                           |   |   |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>  |   |                           | 32. Registrar's Signature<br>  |   |  |   |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

39790

|  |   |                           |   |   |  |   |  |   |  |
|--|---|---------------------------|---|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>JOHN F. HESTER</b>                                     |                           |   |   | 2. Date of Death<br>Month Day Year<br><b>December 23 1997</b>  |   | 3. Time of Death<br><b>5:15 PM</b>   |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>PHYSICIANS MEMORIAL Hospital</b> |                           |   |   | 4b. City, Town, or Location of Death<br><b>La Plata</b>  |   | 4c. County of Death<br><b>CHARLES CO.</b>  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>179-16-4905</b>   |                           | 8. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>APRIL 29, 1911</b>                                   | 9. Birthplace (State or Foreign Country)<br><b>PENNSYLVANIA</b>               |  |
|  | Usual Residence of Decedent   |                           |   |   |  |   |  |   |  |
| 10a. State<br><b>MD</b>  |   | 10b. County<br><b>MLA</b> |   | 10c. City, Town or Location<br><b>BALT, CITY</b>  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
| 10e. Street and Number<br><b>142 N. EAST AVE</b>   |   |                           |   | 10f. Zip Code<br><b>21224</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A</b>   |  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>ARMY</b><br>If Yes, Give Year or Dates: <b>WW II</b>  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                        |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10th</b> College (1-4or 5+) <b>N/A</b>   |   |                           |   | 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SEAMAN</b>              |  | 18b. Kind of Business/Industry<br><b>merchant marines</b>   |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>John J. Hester</b>   |   |                           |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>JULIA L. LAMB</b>  |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Catherine Hartman</b>   |   |                           |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>142 N. EAST AVE, BALT, MD 21224</b> |  |   |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>OAKLAWN cemetery</b>   |   | Date<br><b>12/27/97</b>  |   | 20c. Location - City or Town, State<br><b>BALT, MD</b>   |   |  |
| 21. Signature of Funeral Service Licensee<br><b>[Signature]</b>  |   |                           |   | 22. Name and Address of Facility<br><b>HARTLEY MILLER Funeral Home</b><br><b>7522 HARTFORD RD. BALT, MD 21234</b>                       |  |   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Respiratory Failure</b><br>Due to (or as a consequence of):<br><b>Aspiration Pneumonia</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Sepsis</b> |   |                           |   |   |  |   |  | Approximate Interval Between Onset and Death<br><b>1 DAY</b><br><b>1 week</b> |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |                           |   |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |                           |   |   |  |   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |                           | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |   |                           | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   |  |
|  |   |                           | 28d. Describe how injury occurred   |   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                          |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |                           | 29b. Signature and title of certifier<br><b>[Signature]</b>   |   |  | 29c. License number<br><b>D-44436</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>DEC 24, 1997</b>                    |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ASHVINKUMAR J. Patel</b> <b>Preston Square II Suite 600 Waldorf MD 20603</b>  |   |                           |   |   |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>  |   |                           | 32. Registrar's Signature<br><b>[Signature]</b>   |   |  |   |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be signed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39791

|  |  |   |  |  |  |   |  |  |  |
|--|--|---|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>LYDIA . A. HASS</b>                               |   |  |  | 2. Date of Death<br>Month Day Year<br><b>DECEMBER 28, 1997</b> |   | 3. Time of Death<br><b>11:10 P.M.</b>                            |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>LONG GREEN NURSING HOME</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>BALT. CITY</b>      |   | 4c. County of Death<br><b>N/A</b>                                |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>216-22-0766</b>  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>92</b> Yrs.               |   | 8. Date of Birth (Month, Day, Year)<br><b>SEPTEMBER 11, 1905</b> |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>                                      |   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>BALTIMORE</b>                                |   | 10c. City, Town or Location<br><b>GLEN ARM</b>                   |  |  |
| Usual Residence of Decedent  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>17 WINEBERRY CT.</b>  |  | 10f. Zip Code<br><b>21057</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A</b>                          |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b><br>College (1-4 or 5+) <b>N/A</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>   |  | 16b. Kind of Business/Industry<br><b>Home</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>EDWARD ARNOLD</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ROSE BRAUN</b> |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>JOHN . C. HASS</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>17 WINEBERRY CT GLEN ARM MD, 21057</b>  |  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GREENTMOUNT CREMATORY</b>                                      |  | 20c. Location - City or Town, State<br><b>11/2/98 BALT, MD.</b>        |  |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>HARTLEY MILLER FUNERAL HOME</b><br><b>17527 HARFORD RD, BALT, MD 21234</b>   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Cerebral Vascular Accident</b><br>Due to (or as a consequence of):<br><b>b. Atherosclerosis</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Breast Carcinoma</b><br><b>ASCVD</b> |  | Approximate Interval Between Onset and Death<br><b>1 week</b><br><b>years</b>   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Breast Carcinoma</b><br><b>ASCVD</b>  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicida 4 <input type="checkbox"/> Homicida  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D22645</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>12/30/97</b>  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>FREDRICK SIRKIS M.D. 7151 HOLABIRD AVE BALTO, MD. 21222</b>   |  | 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>   |  | 32. Registrar's Signature<br>  |  |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be filed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 2 should be detached for use as the burial permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39792

|   |   |  |   |  |   |  |  |  |
|---|---|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Buford C. Hebron  |  |   |  | 2. Date of Death<br>Month Day Year<br>December 26, 1997   |  | 3. Time of Death<br>9:45a.m.   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>7928 Brockbridge Road   |  |   |  | 4b. City, Town, or Location of Death<br>Jessup  |  | 4c. County of Death<br>Anne Arundel County   |  |
| Funeral<br>Director                           | 5. Social Security Number<br>705-07-5897 A  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>82 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>Jan. 3, 1915  |  |
|   | Usual Residence of Decedent<br>10e. State<br>Md.  |  | 10b. County<br>Anne Arundel   |  | 10c. City, Town or Location<br>Jessup   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| To Be Completed by Funeral Director           | 10e. Street and Number<br>7928 Brockbridge Road   |  | 10f. Zip Code<br>20794  |  | 10g. Citizen of What Country?<br>USA  |  |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black                               |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>7th Grade   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Contractor/ Cement Finisher          |  | 16b. Kind of Business/Industry<br>Self-Employed   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Moses Hebron   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Lula Gaither   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print) wife<br>Hilda Green Hebron   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7928 Brockbridge Road Jessup, Md. 20794  |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Saint Rest Cemetery   |  | 20c. Location - City or Town, State<br>Dec. 30 Anne Arundel, Md.  |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>Herbert E. Nutter  |  | 22. Name and Address of Facility<br>Nutter Funeral Homes, Inc.<br>2501 Gwynns Falls PKWY Baltimore, Md. 21216                                     |  |   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. COLON CANCER<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Approximate Interval Between Onset and Death<br>2 years |  |   |  |   |  |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |   |  |   |  |  |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |  |
|   |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred   |  |  |  |
|   |   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |   |  |  |  |
|   | 29b. Signature and title of certifier<br>John F. Fish MD  |  |   |  | 29c. License number<br>D 51860  |  | 29d. Date signed (Month, Day, Year)<br>DECEMBER 29, 1997                                       |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>JONATHAN FISH MD 3460 ELLICOTT CENTER DRIVE SUITE 113 ELLICOTT CITY, MD 21043   |  |   |  |   |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br>DEC 31 1997  |  | 32. Registrar's Signature<br>Julia Davidson-Randall   |  |   |  |  |  |

Baltimore, Maryland 21215-0020

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68766

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item 7 Per FH Film G754 12-31-97 rja

Certificate of Death

Reg. No.

97 39793

|  |   |   |   |  |  |   |  |   |
|--|---|---|---|--|--|---|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>DIANE HARRISON</b>                               |   |   |  | 2. Date of Death<br>Month <b>December</b> Day <b>27</b> Year <b>1997</b>   |   | 3. Time of Death<br><b>08:27 AM</b>  |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>JOHNS HOPKINS HOSPITAL</b> |   |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |   | 4c. County of Death<br><b>Baltimore City</b>   |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>213-52-8740</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>48</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>February 17, 1948</b>                                | 9. Birthplace (State or Foreign Country)<br><b>Baltimore, Maryland</b>  |
|  | Usual Residence of Decedent   |   |   |  |  |   |  |   |
| 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Baltimore City</b>  |   | 10c. City, Town or Location<br><b>Baltimore</b>  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
| 10e. Street and Number<br><b>3224 Kenyon Avenue</b>  |   |   |   | 10f. Zip Code<br><b>21213</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>N/A</b>  |   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>                        |  |   | 16b. Kind of Business/Industry<br><b>Housekeeping-Own Home</b>                                 |   |
| 17. Father's Name (First, Middle, Last)<br><b>Chester P. Bajkowski</b>   |   |   |   |  | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Catherine R. Wortek</b>  |   |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>George R. Harrison (Husband)</b>  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3224 Kenyon Avenue Baltimore, Maryland 21213</b> |  |   |  |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>Entombment</b>  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Oak Lawn Cemetery</b>  |  |  | Date<br><b>December 31, 1997</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>       |
| 21. Signature of Funeral Service Licensee<br><b>Elizabeth Holt</b>   |   |   |   | 22. Name and Address of Facility<br><b>Lassahn Funeral Home, Inc.</b><br><b>7401 Belair Road Baltimore, Maryland 21236-4625</b>                      |  |   |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |   |  |  |   |  | Approximate Interval Between Onset and Death                            |
| Immediate Cause (Final disease or condition resulting in death)<br><b>LIVER FAILURE</b>  |   |   |   |  |  |   |  | <b>1 month</b>  |
| Due to (or as a consequence of):<br><b>CROHN'S DISEASE</b>   |   |   |   |  |  |   |  | <b>30 years</b>   |
| Due to (or as a consequence of):   |   |   |   |  |  |   |  |   |
| Due to (or as a consequence of):   |   |   |   |  |  |   |  |   |
| Due to (or as a consequence of):   |   |   |   |  |  |   |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Right hand arterial insufficiency</b><br><b>Disseminated Intravascular Coagulopathy</b>   |   |   |   |  |  |   |  |   |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |   |   |  |  |   |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred                                       |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><b>Elizabeth Holt, MD, Medical Resident</b>  |   | 29c. License number<br><b>RES-000</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>December 28, 1997</b>                             |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Elizabeth Holt, MD Tower 110 Johns Hopkins Hospital Baltimore, MARYLAND</b>   |   |   |   |  |  |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>  |   |   | 32. Registrar's Signature<br><b>John R. ...</b>   |  |  |   |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23a or 28a-e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39794

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Herman A. Hull</b>  |  |   |  | 2. Date of Death<br>Month <b>DEC</b> Day <b>24</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>4:15 AM</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>9000 Briarcroft Lane #115</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Laurel</b>   |  | 4c. County of Death<br><b>Prince Georges</b>  |  |
| 5. Social Security Number<br><b>214-16-0185</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>JULY 3, 1915</b>  |  |
| 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b>   |  |   |  |   |  |   |  |
| Usual Residence of Decedent  |  |   |  |   |  |   |  |
| 10a. State<br><b>Md.</b>   |  | 10b. County<br><b>Prince George</b>   |  | 10c. City, Town or Location<br><b>Laurel</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 10e. Street and Number<br><b>9000 Briarcroft Lane #115</b>   |  |   |  | 10f. Zip Code<br><b>20708</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b></b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Dietary Assistant</b>   |  | 16b. Kind of Business/Industry<br><b>State of Maryland</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Harry Hull</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Edna Mellott</b>  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Rayetta M. Hull - wife</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9000 Briarcroft Lane #115, Laurel, Md. 20708</b>  |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Meadowridge Memorial Pk.</b>   |  | Date<br><b>12/29/97</b>   |  | 20c. Location - City or Town, State<br><b>Elkridge, Md.</b>   |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Gary L. Kaufman Funeral Home at Meadowridge MP<br/>7250 Washington Blvd., Elkridge, Md. 21075</b>  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Myocardial Infarction</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  | Approximate Interval Between Onset and Death<br><b>1 hour</b>   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Coronary Artery Disease</b>   |  |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|  |  |   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|  |  |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner  |  | 29b. Signature and title of certifier<br>  |  |   |  |   |  |
|  |  | 29c. License number<br><b>025430</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>12/26/97</b>  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>John MARGOLIS 14333 Laurel Bowie Rd #307 Laurel, MD 20708</b>   |  |   |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>  |  | 32. Registrar's Signature<br>  |  |   |  |   |  |

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39795

|   |   |   |   |   |   |  |  |  |  |  |                |                |
|---|---|---|---|---|---|--|--|--|--|--|----------------|----------------|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>CHARLES EVANS HILTABIDLE</b>   |   |   |   | 2. Date of Death<br>Month Day Year<br><b>DECEMBER 24 1997</b>   |  | 3. Time of Death<br><b>2257</b>  |  |  |  |                |                |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>SAINT AGNES HOSPITAL 900 CATON AVENUE</b>  |   |   |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death<br><b>BALTIMORE</b>  |  |  |  |                |                |
| Funeral<br>Director   | 5. Social Security Number<br><b>212-34-3070</b>   |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>61</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>May 16 1936</b>  |  |  |  |                |                |
|   | Usual Residence of Decedent   |   | 9. Birthplace (State or Foreign Country)<br><b>Washington D.C.</b>  |   |   |  |  |  |  |  |                |                |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>   |   | 10b. County<br><b>Queen Anne's</b>  |   | 10c. City, Town or Location<br><b>Grasonville</b>   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |  |                |                |
|   | 10e. Street and Number<br><b>Scotts Marina - P.O. Box 606</b>   |   |   |   | 10f. Zip Code<br><b>21638</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |  |                |                |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                            |  |  |  |                |                |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>3</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Charter Captain</b>                   |   | 16b. Kind of Business/Industry<br><b>Boating</b>  |  |  |  |  |  |                |                |
|   | 17. Father's Name (First, Middle, Last)<br><b>Walter Eli Hiltabidle</b>   |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Beatrice Bartholf</b>   |  |  |  |  |  |                |                |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Lynn H. Butler - Daughter</b>  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6406 Queens Chapel Road, University Park, MD 20782</b>  |  |  |  |  |  |                |                |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>  |   | Date<br><b>12/26</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>  |  |  |  |                |                |
|   | 21. Signature of Funeral Service Licensee<br>   |   |   |   | 22. Name and Address of Facility<br><b>Hardesty Funeral Home, P.A.<br/>12 Ridgely Ave. Annapolis MD 21401</b>   |  |  |  |  |  |                |                |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |   |   |  |  |  |  |  |                |                |
|   | <table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Due to (or as a consequence of):<br/>           a. <b>myocardial infarction</b><br/>           Due to (or as a consequence of):<br/>           b. <b>atherosclerotic cardiovascular disease</b><br/>           Due to (or as a consequence of):<br/>           c. <br/>           Due to (or as a consequence of):<br/>           d.         </td> <td>Approximate Interval Between Onset and Death</td> </tr> <tr> <td><b>unknown</b></td> </tr> <tr> <td><b>unknown</b></td> </tr> <tr> <td></td> </tr> </table> |   |   |   |   |  |  |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Due to (or as a consequence of):<br>a. <b>myocardial infarction</b><br>Due to (or as a consequence of):<br>b. <b>atherosclerotic cardiovascular disease</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d. | Approximate Interval Between Onset and Death | <b>unknown</b> | <b>unknown</b> |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Due to (or as a consequence of):<br>a. <b>myocardial infarction</b><br>Due to (or as a consequence of):<br>b. <b>atherosclerotic cardiovascular disease</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.  | Approximate Interval Between Onset and Death  |   |   |   |   |  |  |  |  |  |                |                |
|   | <b>unknown</b>  |   |   |   |   |  |  |  |  |  |                |                |
|   | <b>unknown</b>  |   |   |   |   |  |  |  |  |  |                |                |
|   |   |   |   |   |   |  |  |  |  |  |                |                |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |  |  |  |                |                |
|   |   |   |   |   |   | 24e. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |  |                |                |
|   |   |   |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |  |                |                |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |   |  |  |  |  |  |                |                |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>                                 |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |  |                |                |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28d. Describe how injury occurred                               |   |  |  |  |  |  |                |                |
|   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |   |  |  |  |  |  |                |                |
| 29e. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |   |   |  |  |  |  |  |                |                |
| 29b. Signature and title of certifier<br><br><b>Attending Physician</b>   |   | 29c. License number<br><b>DS1583</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>December 25, 1997</b> |   |  |  |  |  |  |                |                |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Michael Silverman MD St Agnes Hospital Baltimore 21229</b>   |   |   |   |   |   |  |  |  |  |  |                |                |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>   |   | 32. Registrar's Signature<br>   |   |   |   |  |  |  |  |  |                |                |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23e or 28e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39796

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>SHELDON LEE HYMOWITZ</b>  |  | 2. Date of Death<br>Month <b>December</b> Day <b>23</b> Year <b>97</b>   |   | 3. Time of Death<br><b>7:35pm</b>              |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>HOSPICE OF BALTIMORE GILCHRIST CENTER</b> |  | 4b. City, Town, or Location of Death<br><b>TOWSON</b>  |   | 4c. County of Death<br><b>BALTIMORE</b>        |
| Funeral<br>Director   | 5. Social Security Number<br><b>220-22-2213</b>  | 6. Sex<br><b>XX</b> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                 |
|   | 8. Date of Birth (Month, Day, Year)<br><b>MAR. 23, 1928</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |   |  |
| Usual Residence of Decedent   |  |  |  |   |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>BALTIMORE</b>  |  | 10c. City, Town or Location<br><b>BALTIMORE</b>   |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |   |  |
| 10e. Street and Number<br><b>2455 FOREST GREEN ROAD</b>   |  |  | 10f. Zip Code<br><b>21209</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b> |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>AIR FORCE</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |  |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>PRESIDENT</b>  |  | 16b. Kind of Business/Industry<br><b>FINLEIGH CLOTHING CO.</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>ISIDORE JOSEPH HYMOWITZ</b>   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARY FRIEDLANDER</b>   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>MARY B. HYMOWITZ / WIFE</b>  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2455 FOREST GREEN ROAD BALTIMORE, MD 21209</b> |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>BALTIMORE HEBREW</b>  |  | 20c. Location - City or Town, State<br><b>12/26/97 REISTERSTOWN, MD</b>   |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Sol Levinson &amp; Bros., Inc.<br/>8900 Reisterstown Road Pikesville, MD 21208</b>  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Large cell Lymphoma</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Approximate Interval Between Onset and Death<br><b>6 months</b> |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b> |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how Injury occurred  |  |   |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |  |   |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D25205</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>December 24, 1997</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>W.A. Riley GBMC 6701 N. Charles St. Balto. md 21204</b>  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>   |  | 32. Registrar's Signature<br>   |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

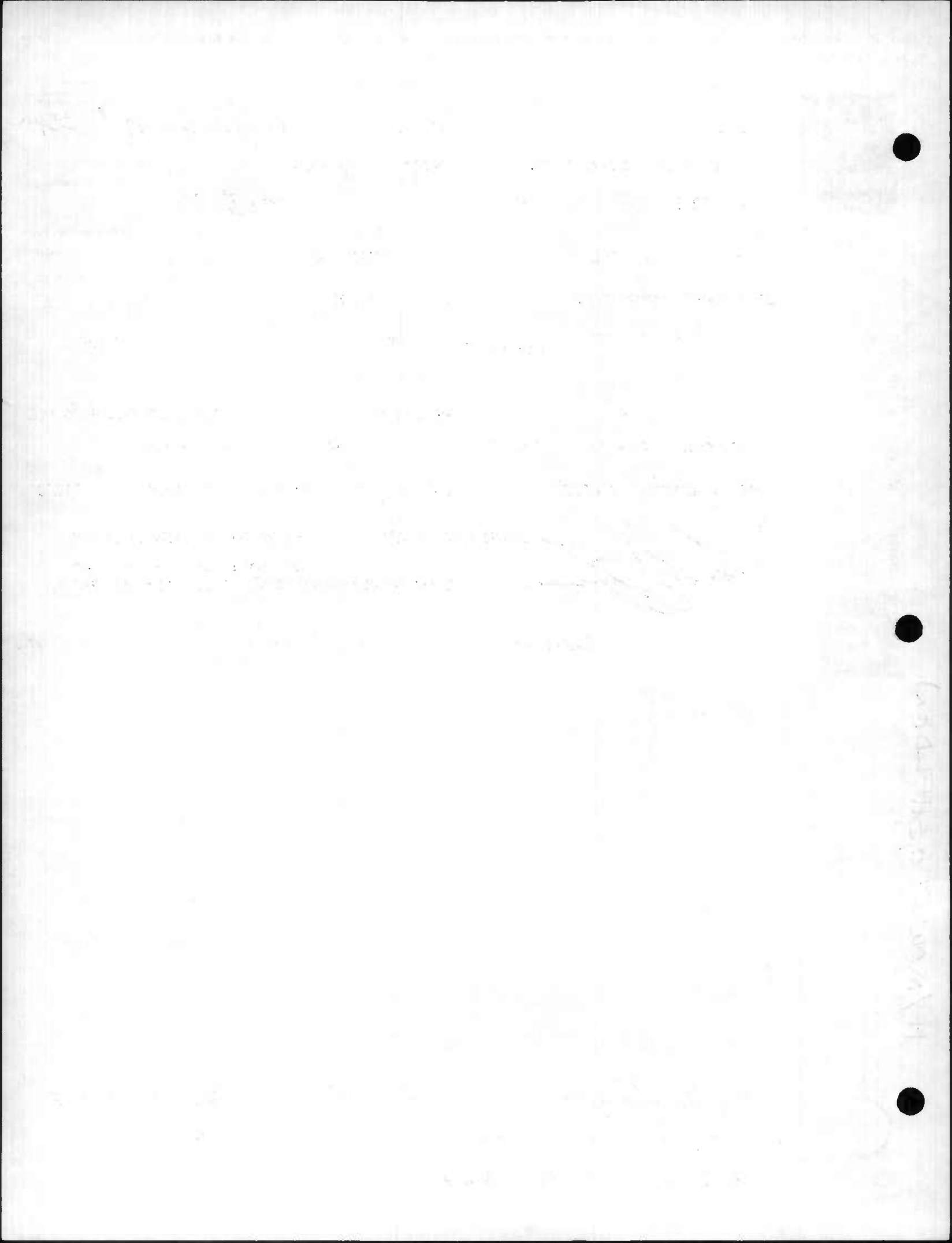
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

HYMOWITZ, SHELDON  
Division of Vital Records, P.O. Box 68760,

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39797

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

L. VIRGINIA HOFFMAN

2. Date of Death

December 28, 1997

3. Time of Death

5:45 AM

4a. Facility Name (If not Institution, give street and number)

AUGSBURG LUTHERAN HOME

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

160-10-4072

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MARCH 22, 1912

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

ARBUTUS

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1229 CIRCLE DRIVE

10f. Zip Code

21227

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12TH GRADE

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

SECRETARY

16b. Kind of Business/Industry

MD HOUSING CORP.

17. Father's Name (First, Middle, Last)

CHARLES E. WILFORD, SR.

18. Mother's Name (First, Middle, Maiden Surname)

CATHERINE MAUDE CLARKE

19a. Informant's Name/Relationship (Type, Print)

ROBERT C. HOFFMAN, SR (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6201 COLLINS WAY ROAD - CATONSVILLE, MD. 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

LORRAINE PARK CEMETERY

Date

01/02/97 BALTIMORE

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

HUBBARD FUNERAL HOME INC.

4107 WILKENS AVENUE-BALTIMORE, MD 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

end-stage liver disease

Approximate Interval Between Onset and Death

months

b.

Due to (or as a consequence of):

hereditary hemochromatosis

years

c.

Due to (or as a consequence of):

d.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

D37573

29d. Date signed (Month, Day, Year)

December 27, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Jeff Zibell MD 7220 Park Heights Ave. Baltimore MD 21208

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

*[Signature]*

State  
Registrar

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

VIRGINIA L. HOFFMAN

10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39798

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Frances Eleanor Jones

2. Date of Death

December 22, 1997

3. Time of Death

2:04 PM

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

219-38-3851

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

55

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 14, 1942

9. Birthplace (State or Foreign Country)

Kentucky

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4527 A Ridge Road

10f. Zip Code

21236

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
10th grade

College (1-4 or 5+)

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Waitress

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Theodore Roosevelt

DeZarn

18. Mother's Name (First, Middle, Maiden Surname)

Ada Whittenberger

19a. Informant's Name/Relationship (Type, Print)

Charles E. Jones (husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4527 A Ridge Road, Baltimore, MD 21236

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory

Date

12/24/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Homes, Inc.  
9705 Belair Rd., Baltimore, MD 21236

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Intra cerebral hematoma  
Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last.

b. Cerebral herniation and death  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Known cerebral aneurysm

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

051977

29d. Date signed (Month, Day, Year)

12/23/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles Park, 19 Fontana Lane Suite 206, Baltimore MD 21237

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39799

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Donald S. Johnson

2. Date of Death

December 26, 1997

3. Time of Death

5:00am

Funeral  
Director

4a. Facility Name (If not Institution, give street and number)

485 Rita Drive

4b. City, Town, or Location of Death

Odenton

4c. County of Death

Anne Arundel

5. Social Security Number

307-30-9452

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 17, 1929

9. Birthplace (State or Foreign Country)

Indiana

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Odenton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

485 Rita Drive

10f. Zip Code

21113

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1948-68

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SFC

16b. Kind of Business/Industry

US Army

17. Father's Name (First, Middle, Last)

Leonard Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Mary M. Barr

19a. Informant's Name/Relationship (Type, Print)

Taeko Johnson - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

485 Rita Drive, Odenton, MD 21113

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

12/26

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hardesty Funeral Home, P.A.  
12 Ridgely Ave. Annapolis, MD 21401

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cancer of the Tongue

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

18 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Ischemic Heart Disease

COPD

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

038409

29d. Date signed (Month, Day, Year)

12/26/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 Easton Ave Baltimore, Md 21224 WILLIAM H. SHARFMAN

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



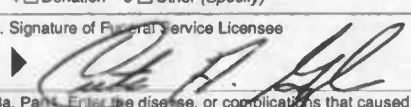
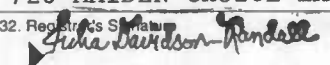
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39800

|  |   |                                 |   |   |  |  |   |   |   |  |   |  |  |
|--|---|---------------------------------|---|---|--|--|---|---|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>MYRTLE M. JESTER</b>                         |                                 |   |   |  |  | 2. Date of Death<br>Month Day Year<br><b>DECEMBER 22, 1997</b>                              |   |   | 3. Time of Death<br><b>3:00 A.M.</b>   |   |  |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>3722 BENSON AVENUE</b> |                                 |   |   |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>                                    |   |   | 4c. County of Death<br><b>BALTIMORE</b>  |   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>216-34-1902</b>   |                                 | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs. |  | If Under 1 Year<br>Months Days  |   | If Under 24 Hrs.<br>Hours Min.  |  | 8. Date of Birth<br>(Month, Day, Year)<br><b>OCT 01, 1912</b> | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>    |  |
|  | Usual Residence of Decedent   |                                 |   |   |  |  |   |   |   |  |   |  |  |
| 10a. State<br><b>MD</b>  |   | 10b. County<br><b>BALITMORE</b> |   | 10c. City, Town or Location<br><b>BALTIMORE</b> |  |  |   |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |
| 10e. Street and Number<br><b>3722 BENSON AVENUE</b>  |   |                                 |   |   |  | 10f. Zip Code<br><b>21227</b>  |   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |  |   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   |                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9TH GRADE</b> College (1-4or 5+)   |   |                                 |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>  |   |   | 16b. Kind of Business/Industry<br><b>HOMEMAKING</b>                     |  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>GEORGE DOLL</b>  |   |                                 |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARY SELBY</b>   |   |   |   |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>BETTY SWITZER(NIECE)</b>  |   |                                 |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>232 CARROLL ROAD - PASADENA, MD. 21122</b>   |   |   |   |  |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |                                 | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>NEW CATHEDRAL CEMETERY</b>   |   |  | Date<br><b>12/30/97</b>  |   | 20c. Location - City or Town, State<br><b>BALTIMORE</b> |   |  |   |  |  |
| 21. Signature of Funeral Service Licensee<br>  |   |                                 |   |   |  | 22. Name and Address of Facility<br><b>HUBBARD FUNERAL HOME INC.<br/>4107 WILKENS AVENUE-BALTIMORE, MD 21229</b>   |   |   |   |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Systemic lupus</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   |                                 |   |   |  |  |   |   |   |  |   | Approximate Interval Between Onset and Death<br><b>4 years</b> |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |                                 |   |   |  |  |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |  |  |
|  |   |                                 |   |   |  |  |   |   |   | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |
|  |   |                                 |   |   |  |  |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |                                 | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |   |   |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |   |                                 | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>                  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred                                       |  |   |  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |   |                                 |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |   |  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |                                 |   |   |  |  |   |   |   |  |   |  |  |
| 29b. Signature and title of certifier<br><br><b>DR. WAFER S. GAMIL M.D.</b>   |   |                                 |   |   |  | 29c. License number<br><b>D50607</b>   |   |   | 29d. Date signed (Month, Day, Year)<br><b>December 29 - 1997</b>        |  |   |  |  |
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print)<br><b>DR. WAFER S. GAMIL - 720 MAIDEN CHOICE LANE-SUITE "C"-BALTIMORE, MD 21228</b>   |   |                                 |   |   |  |  |   |   |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>  |   |                                 | 32. Registrar's Signature<br>  |   |  |  |   |   |   |  |   |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOSEPH MARION KOZLOWSKI SR.

2. Date of Death  
Month

Day

Year

December 25, 1997

3. Time of Death

5:30 p.m.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

5. Social Security Number

212-34-0294

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

61

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 8, 1936

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1400 N. Fountain Green Road

10f. Zip Code

21015

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
10th grade

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Heavy Equipment Mechanic

16b. Kind of Business/Industry

Sand &amp; Gravel Co.

17. Father's Name (First, Middle, Last)

Joseph Kozlowski

18. Mother's Name (First, Middle, Maiden Surname)

Agnes Bolewicki

19a. Informant's Name/Relationship (Type, Print)

Joseph M. Kozlowski Jr. (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4002 Sharilynn Drive, Abingdon, MD. 21009

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

St. Mary's Church Cem.

Date

12/29/97

20c. Location - City or Town, State

Pylesville, Maryland

21. Signature of Funeral Service Licensee

Robert Madachy

22. Name and Address of Facility

Schimunek Funeral Home of Bel Air, Inc.  
610 W. MacPhail Road, Bel Air, MD. 2101423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

Approximate  
Interval Between  
Onset and Death

30 minutes

Due to (or as a consequence of):

b. ASCVD

10 YEARS

Due to (or as a consequence of):

c. Hypertension

10 YEARS

Due to (or as a consequence of):

Sequitally list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

COPD

Peripheral Vascular disease

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending  
Investigation 6 ☐ Could not be  
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

Stanley Kman DO

29c. License number

H41069

29d. Date signed (Month, Day, Year)

DECEMBER 26, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR Stanley Kman 1308 Business Center Way #102 Edgewood.

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

Jill Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

10-11-68  
10-11-68  
10-11-68

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 10-11-68 BY 1045

10-11-68  
10-11-68

X  
X  
X  
X

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 10-11-68 BY 1045

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39802

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLES TUGHMAN KREINER

2. Date of Death

Month

Day

Year

DECEMBER 29, 1997

3. Time of Death

9:35 AM

4a. Facility Name (If not institution, give street and number)

105 D. WALDON ROAD

4b. City, Town, or Location of Death

AGINCOURT

4c. County of Death

HARFORD

Funeral  
Director

5. Social Security Number

212-20-6638

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months

If Under 24 Hrs.

Hours

6. Date of Birth

(Month, Day, Year)

JUNE 24, 1927

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

CT.

10b. County

FAIRFIELD

10c. City, Town or Location

STAMFORD

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

8 DOOLITTLE ROAD

10f. Zip Code

06902

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates: W.W.II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 YRS.

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SALES

16b. Kind of Business/Industry

GRAPHIC ARTS + PRINTING

17. Father's Name (First, Middle, Last)

ALBERT L. KREINER, SR.

18. Mother's Name (First, Middle, Maiden Surname)

ELIZABETH L. HEMSLY

19a. Informant's Name/Relationship (Type, Print)

JEAN KREINER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8 DOOLITTLE ROAD STAMFORD, CT. 06902

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

NEW CATHOLICAL

Date

JAN. 3 1998

20c. Location - City or Town, State

BALTIMORE MARYLAND

21. Signature of Funeral Director

[Signature]

22. Name and Address of Facility

EVANS FUNERAL CHAPEL - BEL AIR, P.A. 21050

3 NEWPORT DRIVE FOREST HILL MARYLAND

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Coronary Artery Disease

Due to (or as a consequence of):

b. ASCVD

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending Investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

NA

28b. Time of Injury

NA

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

NA

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

NA

28f. Location (Street and Number or Rural Route Number, City or Town, State)

NA

29a. Certifier (Check only one)

☐ Certifying Physician☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] DME

29c. License number

OCME

29d. Date signed (Month, Day, Year)

DECEMBER 31, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

G.S. Prabhu M.D. 218 Fulford Ave Bel Air MD. 21014 410-879-6564

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39803

Physician  
/Medical  
Examiner

1. Decedant's Name (First, Middle, Last)

Lawrence J. Kraus

2. Date of Death

Month Day Year  
December 23, 1997

3. Time of Death

8:10 p.m.

Funeral  
Director

4a. Facility Name (If not Institution, give street and number)

6546 Blackhead Road

4b. City, Town, or Location of Death

Baltimore County

4c. County of Death

Baltimore

5. Social Security Number

220-18-9174

6. Sex

1 ☒ M 2 ☐ F  
X

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 15, 1926

9. Birthplace (State or Foreign Country)

Fullerton, Maryland

Usual Residence of Decedant

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore County

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6546 Blackhead Road

10f. Zip Code

21220

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1945-194613. Was Decedant of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedant's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
N/A16a. Decedant's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Electrician

16b. Kind of Business/Industry

Electrical Industry

17. Father's Name (First, Middle, Last)

John L. Kraus

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Snyder

19a. Informant's Name/Relationship (Type, Print)

Joann M. Gojin (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6517 Belle Vista Avenue Baltimore, Maryland 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

St. Joseph Church Cem. Dec. 29, 1997

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Mother Joseph Chojacki

22. Name and Address of Facility

Lassahn Funeral Home, Inc.

7401 Belair Road Baltimore, Maryland 21236-4625

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)e. Hepatorenal syndrome  
Dua to (or as a consequence of):b. Cirrhosis  
Dua to (or as a consequence of):c. Alcohol abuse  
Dua to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Portal hypertension

Anchites

Anemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Cheryl [Signature]

29c. License number

D 22200

29d. Date signed (Month, Day, Year)

12/26/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARK P. DIAMOND MD 9105 FRANKLIN SQ. DR. BALT. MD 21237

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

John Davidson [Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Item : 10a Per MEO Film G-754 12-31-97RC

Reg. No.

97 39804

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Gertrude

Kaeder

2. Date of Death

Month Day Year  
December 17 1997

3. Time of Death

10:50 pm

4a. Facility Name (If not institution, give street and number)

Stella Maris Nursing Home

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

226-46-8101

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 13, 1918

9. Birthplace (State or Foreign Country)

Germany

Usual Residence of Decedent

10a. State

Maryland  
MARYLAND

10b. County

Baltimore

10c. City, Town or Location

Phoenix

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13407 Blythenia Road

10f. Zip Code

21131

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
016a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Paymaster

16b. Kind of Business/Industry

Aircraft Manufacturer

17. Father's Name (First, Middle, Last)

Hubert Kaeder

18. Mother's Name (First, Middle, Maiden Surname)

Magdalene Kremer

19a. Informant's Name/Relationship (Type, Print)

Anne C. Riley

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13407 Blythenia Road, Phoenix, Maryland 21131

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☒ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore Street  
Baltimore, Maryland 2120123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Collagen Vascular Disease

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death.) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending  
Investigation  
6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury et  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D 15504

29d. Date signed (Month, Day, Year)

12-17-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eddie Nakhuda, M.D. 2300 Dulaney Valley Rd Timonium, Md 21093

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

Julia Davidson-Randall

Baltimore, Maryland 21215-0020

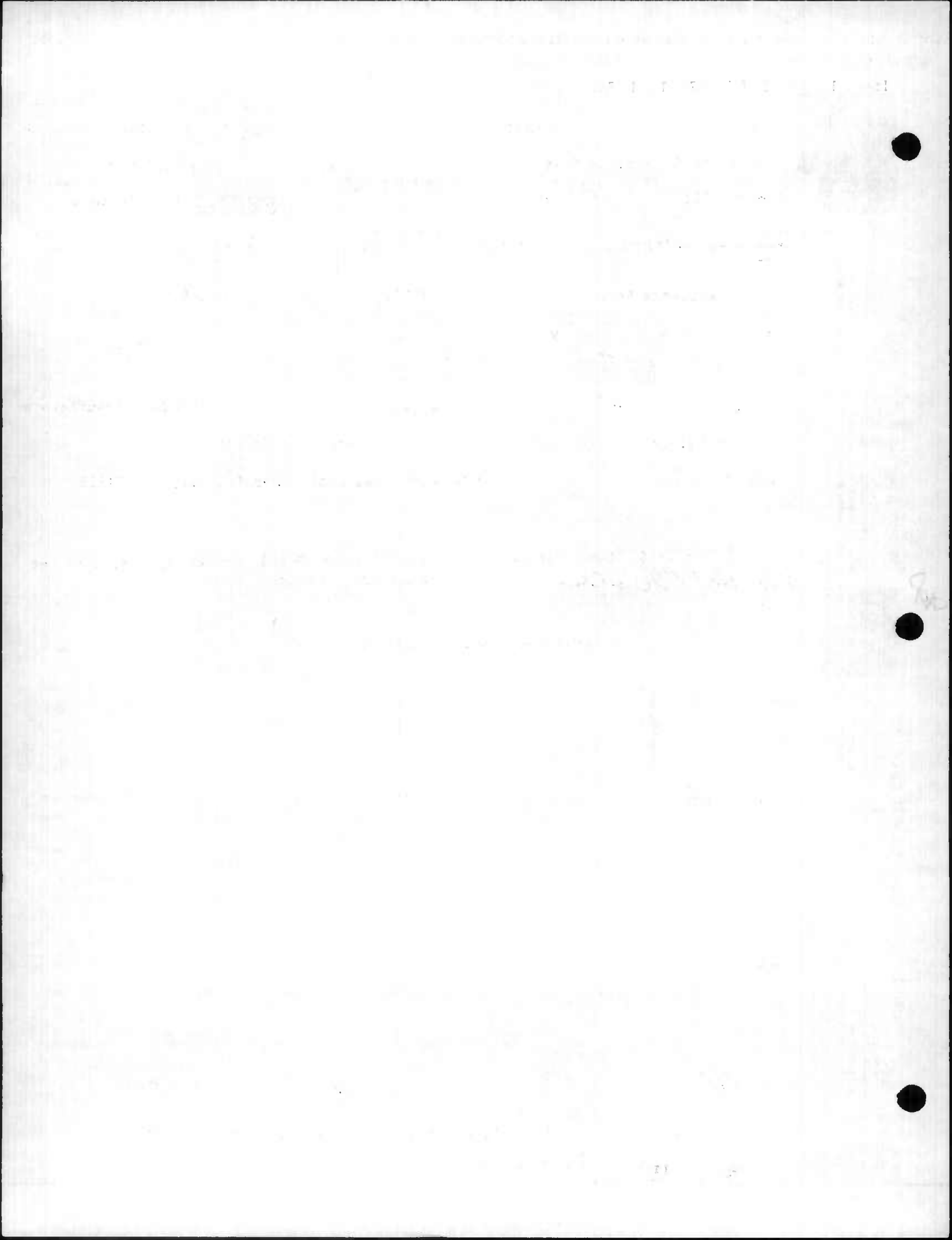
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39805

|  |   |  |   |  |  |  |  |  |
|--|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>DEBORAH LEE</b>  |  |   |  | 2. Date of Death<br>Month <b>December</b> Day <b>26</b> , Year <b>1997</b>   |  | 3. Time of Death<br><b>11:25 a.m.</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>STELLA MARIS HOSPICE</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>TOWSON</b>  |  | 4c. County of Death<br><b>Balto.</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>544-80-1034</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs. | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Dec 20, 1914</b>                                     |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Korea</b>  |  |   |  |  |  |  |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent   |  |   |  |  |  |  |  |
|  | 10a. State<br><b>MD.</b>  |  | 10b. County<br><b>BALTIMORE</b>   |  | 10c. City, Town or Location<br><b>PARKVILLE</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | 10e. Street and Number<br><b>8600 ELLEN COURT</b>   |  |   |  | 10f. Zip Code<br><b>21234</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Korean</b>                       |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> Collegia (1-4 or 5+) <b>4</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>                     |  | 16b. Kind of Business/Industry<br><b>Home</b>  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>UNKNOWN</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Um CHUN CHON</b>   |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Don Lee</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8600 Ellen Ct Balto. Md. 21234</b>   |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>DULANEY VALLEY Memorial Gd.</b>                                      |  | Date<br><b>Dec 29 1997</b>   |  | 20c. Location - City or Town, State<br><b>Timonium, Md</b>                                     |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Evans Chapel of Memories 8800 Harford Rd. Balto. Md 21234</b>   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. Metastatic Cancer</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |
|  |   |  |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
|  |   |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b> |   |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br><b>M</b>                  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28d. Describe how injury occurred                |  |  |  |  |
|  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br>  |   |  |   | 29c. License number<br><b>844128</b>             |  | 29d. Date signed (Month, Day, Year)<br><b>12/26/97</b>   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DR. PENELOPE EDWARDS 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093</b>   |   |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>  |   | 32. Registrar's Signature<br>  |   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21268-0760



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 97 39806

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

ALAN B. LESLIE III

2. Date of Death  
Month Day Year  
DECEMBER 27, 19973. Time of Death  
3:40 P

4a. Facility Name (If not institution, give street and number)

829 HARLEM AVE.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

5. Social Security Number

6. Sex  
1 ☒ M 2 ☐ F7. Age (In yrs. last birthday)  
Yrs. 61If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)  
NOV 22, 19369. Birthplace (State or Foreign  
Country)  
BALTIMORE, MD.

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

829 HARLEM AVE.

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: AFRO AMERICAN

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Unknown

16b. Kind of Business/Industry

Unknown

17. Father's Name (First, Middle, Last)

THOMAS LESLIE

18. Mother's Name (First, Middle, Maiden Surname)

MARY ALICE LESLIE

19a. Informant's Name/Relationship (Type, Print)

MILDRED HORN SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5513 GWYNN OAK AVE, BALTIMORE, MARYLAND 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

MT. ZION CEMETERY

Date

12/30/97 LANSDOWN, MD.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ESTEP BROTHERS FUNERAL HOME, P.A.  
1300 EUTAW PLACE, BALTIMORE, MARYLAND 2121723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No26. Place of Death (Check only one)  
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury  
M28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

OCME

29d. Date signed (Month, Day, Year)

DECEMBER 28, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. C. Allen, MD

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39807

Physician  
/Medical  
ExaminerFuneral  
Director

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>ABRAM LEWKOWICZ</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>December 22, 1997</b>   |  | 3. Time of Death<br><b>9:28 pm</b>   |  |
| 4a. Facility Name (If not Institution, give street and number)<br><b>2909 FALLSTAFF ROAD #16</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>N/A</b>  |  |
| 5. Social Security Number<br><b>213-54-0587</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>JULY 3, 1914</b>   |  |
| 9. Birthplace (State or Foreign Country)<br><b>POLAND</b>   |  |   |  |  |  |  |  |
| Usual Residence of Decedent   |  |   |  |  |  |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>2909 FALLSTAFF ROAD #16</b>  |  |   |  | 10f. Zip Code<br><b>21209</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> Collage (1-4or 5+) <b></b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>ELECTRICIAN</b>  |  | 16b. Kind of Business/Industry<br><b>BALTIMORE CITY</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>LEJB LEWKOWICZ</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>DEBORAH UNOBTAINABLE</b>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>MIRIAM LEWKOWICZ / WIFE</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2909 FALLSTAFF ROAD #16 BALTIMORE, MD 21209</b>  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>BETH TFILOH CONGREGATION</b>   |  | 20c. Location - City or Town, State<br><b>12/24/97 BALTIMORE, MD</b>   |  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Sol Levinson &amp; Bros., Inc.<br/>5900 Reisterstown Road Pikesville, MD 21208</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>Neutropenia with pneumonia 2° to:</b><br>Due to (or as a consequence of):<br>b. <b>Myelodysplastic Syndrome</b><br>Due to (or as a consequence of):<br>c. <b>Heart failure &amp; coronary artery D2</b><br>Due to (or as a consequence of):<br>d. <b></b> |  |   |  | Approximate Interval Between Onset and Death   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|   |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|   |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA                                  |  | 26. Place of Death (Check only one)<br>Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury et Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|   |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |
|   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>H0051339</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>December 23, 1997</b>  |  |
| 30. Name and address of person who completed cause of death (Item 22a) (Type, Print)<br><b>Laura J. Harlan 7220 Park Heights Ave, Balto MD 21208</b>  |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>   |  | 32. Registrar's Signature<br>   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

• • •

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39808

Item:18 per FH G-754 12/30/97 dh

Physician  
/Medical  
Examiner

Funeral  
Director

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>LEONARD L LITVINSKY</b>  |  |   |  | 2. Date of Death<br>Month <b>DECEMBER</b> Day <b>24</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>6:24am</b>                                       |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>SUBURBAN HOSPITAL</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>BETHESDA</b>  |  | 4c. County of Death<br><b>MONTGOMERY</b>                                |  |
| 5. Social Security Number<br><b>212-01-1209</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>FEB. 3, 1914</b>              |  |
| 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |  | 10e. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>MONTGOMERY</b>   |  | 10c. City, Town or Location<br><b>ROCKVILLE</b>                         |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  | 10f. Zip Code<br><b>20852</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                             |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SALES MANAGER</b>  |  | 16b. Kind of Business/Industry<br><b>RETAIL</b>                         |  |
| 17. Father's Name (First, Middle, Last)<br><b>JOSEPH DAVID LITVINSKY</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>JENNIE Jennie SALINSKY</b>   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>MRS. MARILYN BLANK / DAUGHTER</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>600 JEFFERSON PLAZA, SUITE 202 ROCKVILLE, MD 20852</b>                                   |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>HAR ZION TIFEREETH ISRAEL</b>  |  | 20c. Location - City or Town, State<br><b>12-26-1997- ROSEDALE, MD</b>   |  | 20d. Date   |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Sol Levinson &amp; Bros., Inc.<br/>8900 Reisterstown Road Baltimore, MD 21208</b>   |  |   |  |

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Pulmonary Embolus</b><br>Due to (or as a consequence of):<br><b>Renal Failure</b><br>Due to (or as a consequence of):<br><b>Arteriosclerotic Vascular Disease</b><br>Due to (or as a consequence of): |  |   |  | Approximate Interval Between Onset and Death<br><b>1 Hour</b><br><b>1 year</b><br><b>30 years</b>  |  |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  | 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D39064</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>DEC. 24, 1997</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. James Salander 1119 Rockville Pike, # 204 Rockville, MD 20852</b>   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>  |  | 32. Registrar's Signature<br>   |  |  |  |

State  
Registrar

Leonard Litvinsky  
Time: 6:24 AM Date: 12/24/97  
Division of Vital Records, P.O. Box 68760,  
Baltimore, Maryland 21215-0020



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39809

|   |   |                                 |   |  |  |  |  |  |
|---|---|---------------------------------|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>TEY (NMN) LARK</b>   |                                 |   |  | 2. Date of Death<br>Month Day Year<br><b>December 29 1997</b>  |  | 3. Time of Death<br><b>930 AM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>2341 MONUMENTAL AVENUE</b>   |                                 |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>BALTIMORE</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>219-01-0508</b>   |                                 | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                 | 8. Date of Birth (Month, Day, Year)<br><b>APRIL 23, 1917</b>                                   | 9. Birthplace (State or Foreign Country)<br><b>VIRGINIA</b>  |
|   | Usual Residence of Decedent   |                                 |   |  |  |  |  |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>MD</b>   | 10b. County<br><b>BALTIMORE</b> |   | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|   | 10e. Street and Number<br><b>2341 MONUMENTAL AVENUE</b>   |                                 |   | 10f. Zip Code<br><b>21227</b>                    |  | 10g. Citizen of What Country?<br><b>U.S.A.</b> |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW II</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                        |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8TH GRADE</b><br>College (1-4 or 5+) <b>Collage</b>   |                                 | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>EQUIPMENT OPERATOR</b>  |  | 16b. Kind of Business/Industry<br><b>ARBUTUS EXECUTIVE CO.</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>GEORGE W. LARK</b>  |                                 |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>VIRGINIA THOMPSON</b>  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>SCOTT E. LARK (BROTHER)</b>  |                                 |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6108 KIRBY ROAD - CLINTON, MD 20735</b>  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |                                 | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GRACE METHODIST CEMETERY</b>   |  | Date<br><b>01/03/97</b>  |  | 20c. Location - City or Town, State<br><b>BALTIMORE</b>  |  |
|   | 21. Signature of Funeral Service Licensee<br>   |                                 | 22. Name and Address of Facility<br><b>HUBBARD FUNERAL HOME INC.<br/>4107 WILKENS AVENUE-BALTIMORE, MD 21229</b>  |  |  |  |  |  |
| Physician<br>/Medical<br>Examiner             | 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b><br>Due to (or as a consequence of):  |                                 |   |  |  |  |  | Approximate Interval Between Onset and Death<br><b>YEARS</b> |
|   | b. Due to (or as a consequence of):   |                                 |   |  |  |  |  |  |
|   | c. Due to (or as a consequence of):   |                                 |   |  |  |  |  |  |
|   | d. Due to (or as a consequence of):   |                                 |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.  |                                 |   |  |  |  |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |                                 |   |  |  |  |  |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |                                 |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |
|   | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |                                 | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accidental 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicidal 4 <input type="checkbox"/> Homicidal   |                                 | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No           |  |
|   |   |                                 | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred  |  |  |  |
|   |   |                                 | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                 |   |  |  |  |  |  |
| State Registrar                               | 29b. Signature and title of certifier<br>  |                                 |   |  | 29c. License number<br><b>D11171</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>December 29, 1997</b>                                |  |
|   | 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br><b>Dr. F. William S. Williams 405 Frederick Ave CATONSVILLE 21228</b>   |                                 |   |  |  |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>   |                                 | 32. Registrar's Signature<br>  |  |  |  |  |  |

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39810

|  |   |   |   |   |  |  |  |  |
|--|---|---|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Ethel H. Lohrfink</b>  |   |   |   | 2. Date of Death<br>Month Day Year<br><b>12 22 97</b>  |  | 3. Time of Death<br><b>11:05 p.m.</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>ST. MARTINS HOME</b>   |   |   |   | 4b. City, Town, or Location of Death<br><b>CATONSVILLE</b>   |  | 4c. County of Death<br><b>BALTIMORE</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-03-8571D</b>  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                          |   | 7. Age (In yrs. last birthday)<br><b>99</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>JUNE 21, 1898</b>  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>BALTO., MD</b>   |   | 10a. State<br><b>MD</b>   |   | 10b. County<br><b>N/A</b>  |  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  |
| To Be Completed by<br>Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |   |   | 10e. Street and Number<br><b>124 W. FRANKLIN ST<br/>709 BASICILLA PLACE APTS</b>   |  | 10f. Zip Code<br><b>21201</b>  |  |
|  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |   |   |   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:              |  |
|  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |   |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12TH GRADE</b><br>College (1-4 or 5+) <b>Collega (1-4 or 5+)</b> |  |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)   |   |   |   | 16b. Kind of Business/Industry   |  | 17. Father's Name (First, Middle, Last)<br><b>WILLIAM EDWARD HARDEN</b>  |  |
|  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARGARET VIRGINIA GETTIER</b>   |   |   |   | 19a. Informant's Name/Relationship (Type, Print)<br><b>SISTER ANN LOHRFINK, S.S.N.D.</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>817 HAMPTON LANE - TOWSON, MD 21286</b>                        |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>NEW CATHEDRAL CEMETERY</b> |   | 20c. Date<br><b>12/27/97</b>   |  | 20d. Location - City or Town, State<br><b>BALTIMORE</b>  |  |
|  | 21. Signature of Funeral Service Licensee<br>   |   |   |   | 22. Name and Address of Facility<br><b>HUBBARD FUNERAL HOME INC.<br/>4107 WILKENS AVENUE-BALITMORE, MD 21229</b>   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>UROSEPSIS</b><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |   |  |  |  |  |
|  | Approximate Interval Between Onset and Death<br><b>1 wk</b>   |   |   |   |  |  |  |  |
|  | Medical Certification: To Be Completed by Physician/Medical Examiner  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Coronary artery disease<br/>Congestive heart failure<br/>Dementia</b>  |   |   |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |   |   |   |   |  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of injury (Month, Day Year)   |   | 28b. Time of injury<br><b>M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred  |   |   |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |
| 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |   |  |  |  |  |
| 29b. Signature and title of certifier<br>   |   |   |   | 29c. License number<br><b>D 21649</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>Dec 23, 1997</b>                           |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SAMBANDAY ASKARAN, 3455 WILKENS AVE. BALTIMORE, MD 21229</b>  |   |   |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>  |   | 32. Registrar's Signature<br>  |   |   |  |  |  |  |



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State of Maryland / Department of Health and Mental Hygiene

97 39811

Item#18 perFH G754 12/31/97 EW

## Certificate of Death

Reg. No.

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|--|--|--|---|---|--|---------------------------------|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Agnes Lieder</b>  |  |   |   | 2. Date of Death<br>Month <b>December</b> Day <b>29</b> Year <b>1997</b>   |                                 |   |   | 3. Time of Death<br><b>2:49 A.M.</b>   |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Stella Maris Hospice</b>  |  |   |   | 4b. City, Town, or Location of Death<br><b>Baltimore County</b>  |                                 |   |   | 4c. County of Death<br><b>Baltimore</b>  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>123-30-9327</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>97</b> Yrs.   |                                 | 8. Date of Birth (Month, Day, Year)<br><b>February 2, 1900</b>    |   | 9. Birthplace (State or Foreign Country)<br><b>Brooklyn, New York</b>  |  |  |
|  | Usual Residence of Decedent  |  |   |   |  |                                 |   |   |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Baltimore</b>   |   | 10c. City, Town or Location<br><b>Baltimore County</b>   |                                 |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
|  | 10e. Street and Number<br><b>1704 Landrake Road</b>  |  |   |   | 10f. Zip Code<br><b>21204</b>  |                                 | 10g. Citizen of What Country?<br><b>USA</b>                       |   |  |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                 |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>N/A</b>  |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>  |                                 |   | 16b. Kind of Business/Industry<br><b>Housekeeping-Own Home</b>  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Edward Camillo Johnsen</b>   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><del>Hansine Mathilde Smith</del> <b>Hansine Hensen</b>   |                                 |   |   |  |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Helen Kubik</b>   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1704 Landrake Road Baltimore, Maryland 21204</b>   |                                 |   |   |  |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc.</b>  |   | 20c. Date<br><b>December 30, 1997</b>  |                                 | 20d. Location - City or Town, State<br><b>Baltimore, Maryland</b> |   |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Boother Bessiah Chojnacki</b>  |  |   |   | 22. Name and Address of Facility<br><b>Lassahn Funeral Home, Inc.<br/>7401 Belair Road Baltimore, Maryland 21236-4625</b>  |                                 |   |   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>DEMENTIA</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>f.<br>Due to (or as a consequence of):<br>g.<br>Due to (or as a consequence of):<br>h.<br>Due to (or as a consequence of): |  |   |   |  |                                 |   |   | Approximate interval Between Onset and Death   |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |                                 |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |   |  |                                 |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                 |   |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  |  |   | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br><b>M</b> |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28d. Describe how injury occurred                      |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   | 29b. Signature and title of certifier<br><b>E. Davidson</b>   |  |                                 |   | 29c. License number<br><b>D25686</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>12-29-97</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>EBRAHIM IPRAKCHI 7600 OSLEN DRIVE BALTIMORE MD 21204</b>  |  |  |   |   |  |                                 |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>  |  |  |   | 32. Registrar's Signature<br><b>E. Davidson</b>   |  |                                 |   |   |  |  |  |

Agnes Lieder

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39812

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |  |                                |  |  |
|---|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Anthony Sheldon Lee Jr.</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>DECEMBER 24, 1997</b>   |                                | 3. Time of Death<br><b>9:15AM</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>200 BLOCK SOUTH FREMONT STREET</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |                                | 4c. County of Death<br><b>N/A</b>  |  |
| 5. Social Security Number<br><b>220-04-1090</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>21</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>Mar 10, 1976</b>   |  |
| 9. Birthplace (State or Foreign Country)<br><b>Md</b>   |  |   |  |  |                                |  |  |
| Usual Residence of Decedent   |  |   |  |  |                                |  |  |
| 10a. State<br><b>Md</b>   |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>4625 Belvieu Avenue</b>  |  |   |  | 10f. Zip Code<br><b>21215</b>  |                                | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b>  |  | College (1-4 or 5+) <b>4 yrs</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Chief Executive Officer</b>  |                                | 16b. Kind of Business/Industry<br><b>Nursing</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Anthony Sheldon Lee Sr.</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Alice Capel Lee</b>  |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Anthony S. Lee (Father)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4625 Belvieu Avenue Baltimore, Md 21215</b>  |                                |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Woodlawn Cemetery 12/30/97</b>   |  | Data   |                                | 20c. Location - City or Town, State<br><b>Baltimore, Md.</b>   |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Caple Funeral Service<br/>5502 Winner Avenue Baltimore, Md 21215</b>  |                                |  |  |
| 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Gunshot Wound of Head</b><br>Due to (or as a consequence of):<br><br><b>b.</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  | Approximate Interval Between Onset and Death   |                                |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|   |  |   |  |  |                                | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |
|   |  |   |  |  |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>IN CAR</b> |  |  |                                |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)<br><b>UNK</b>  |  | 28b. Time of Injury<br><b>UNK</b> M  |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>IN CAR</b>   |  | 28d. Describe how injury occurred<br><b>Subject shot</b>   |                                |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>O.C.M.E.</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>DECEMBER 25, 1997</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>J. L. Ligon, MD 111 Penn Street, Baltimore, Maryland 21201</b>   |  |   |  |  |                                |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>   |  |   |  | 32. Registrar's Signature<br>   |                                |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39813

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HERBERT

LAIEFSKY

2. Date of Death

Month

Day

Year

DECEMBER

19

1997

3. Time of Death

12:15 AM

4a. Facility Name (If not institution, give street and number)

Hebrew Home Of Greater Washington

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

579-16-9982

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Sept. 13, 1921

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

6121 Montrose Road

10f. Zip Code

20852

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 Years

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Public Accountant

16b. Kind of Business/Industry

Accounting

17. Father's Name (First, Middle, Last)

Joseph Laiefsky

18. Mother's Name (First, Middle, Maiden Surname)

Sadie Rimmerman

19a. Informant's Name/Relationship (Type, Print)

Karyn R. Gross, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9498 Vollmerhausen Drive

Columbia, Maryland 21046

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

King David Memorial Garden

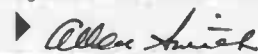
Date

12/21/97

20c. Location - City or Town, State

Falls Church, VA

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

STEIN HEBREW MEMORIAL FUNERAL HOME, INC.

232 CARROLL STREET, NW, WASHINGTON, DC 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. ATHERO SCLEROTIC HEART DISEASE

Due to (or as a consequence of):

YEARSSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETESRENAL INSUFFICIENCY

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending2 ☐ Accident

Investigation

3 ☐ Suicide6 ☐ Could not be4 ☐ Homicide

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

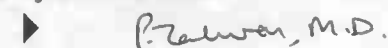
Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D 36552

29d. Date signed (Month, Day, Year)

DECEMBER 19 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

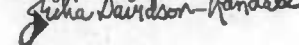
P. TALWAR, 6121 MONTROSE ROAD, ROCKVILLE MD. 20852

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 39814

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ada Margueritte MULKEY

2. Date of Death

Month Day Year  
December 26, 1997

3. Time of Death

5:32 am

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

239-16-0299

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Jan. 19, 1916

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Edgemere

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6709 River Drive Road

10f. Zip Code

21219

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4+ Years

18a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

School Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Caleb Dixon

18. Mother's Name (First, Middle, Maiden Surname)

Ada McPherson

19a. Informant's Name/Relationship (Type, Print)

John J. Mulkey, Jr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

558 Dowitcher Ct. Pasadena, Maryland 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith Cemetery 12/29/97 Baltimore, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Recurrent Pulmonary Embolism

Due to (or as a consequence of):

6 days

b. Deep Vein Thrombosis

Due to (or as a consequence of):

6 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

Paroxysmal Atrial Fibrillation

Hypertension, Cerebrovascular Accident

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ NoHospital: ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

RD 2120

29d. Date signed (Month, Day, Year)

December 26, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Herman Junker M.D. 9000 Franklin Square Drive Baltimore, MD 21237

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39815

|  |  |   |   |                                      |  |  |   |   |   |  |
|--|--|---|---|--------------------------------------|--|--|---|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>SIMON MARSHALL</b>  |   |   |                                      |  | 2. Date of Death<br>Month <b>December</b> Day <b>23</b> Year <b>1997</b>   |   | 3. Time of Death<br><b>10:38 AM</b>                   |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>MERCY MEDICAL CENTER</b>  |   |   |                                      |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |   | 4c. County of Death<br><b>NA</b>                      |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>216-10-4159</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>93</b> Yrs.  | If Under 1 Year<br>Months            | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>6-22-1904</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>VA</b> |   |  |
|  | Usual Residence of Decedent  |   |   |                                      |  |  |   |   |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>  | 10b. County<br><b>NA</b>  | 10c. City, Town or Location<br><b>Baltimore</b>   |                                      |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |   |  |
|  | 10e. Street and Number<br><b>3712 Gelston Drive</b>  |   |   | 10f. Zip Code<br><b>21229</b>        |  | 10g. Citizen of What Country?<br><b>U.S.A</b>  |   |   |   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |   |   |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2nd grade</b> College (1-4 or 5+) <b>NA</b>   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>laborer</b>                    |                                      |  | 16b. Kind of Business/Industry<br><b>Bethlehem Steel</b>   |   |   |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Willie M. Marshall</b>   |   |   |                                      |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rebecca Madison</b>  |   |   |   |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Jean Frazier - Daughter</b>   |   |   |                                      |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3712 Gelston Drive Baltimore, MD 21229</b> |   |   |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MD Nat Memorial Park</b>   |                                      | 20c. Location - City or Town, State<br><b>Laurel, MD</b>   |  | 20d. Date<br><b>12-30-97</b>  |   |   |  |
|  | 21. Signature of Funeral Service Licensee<br><b>John B. Johnson</b>  |   | 22. Name and Address of Facility<br><b>March F. H. West 4300 Wabash Avenue Baltimore, MD 21215</b>  |                                      |  |  |   |   |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. PNEUMONIA</b><br>Due to (or as a consequence of):<br><br><b>b.</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b> |   |   |                                      |  |  |   |   |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |   |                                      |  |  |   |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>RIGHT LUNG RESECTION</b><br><b>HYPERTENSION</b><br><b>CONGESTIVE HEART FAILURE</b>  |  |   |   |                                      |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |                                      |  |  |   |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury<br>(Month, Day, Year)   |   | 28b. Time of Injury<br><b>M</b>      |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred                     |   |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>De H. HODGSON, MD</b>   |   | 29c. License number<br><b>P10228</b> |  | 29d. Date signed (Month, Day, Year)<br><b>12-23-97</b>   |   |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>HANG LY MERCY MEDICAL CENTER, 301 ST. PAUL PLACE, BALTIMORE, MARYLAND 21202</b>   |  |   |   |                                      |  |  |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>  |  | 32. Registrar's Signature<br><b>Julia Hudson-Randall</b>  |   |                                      |  |  |   |   |   |  |

Baltimore, Maryland 21215-0020

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760

State  
Registrar



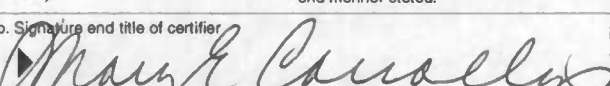
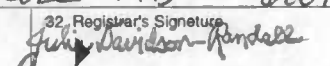
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39816

|  |   |  |   |  |   |  |  |  |
|--|---|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>Henrietta E. Melvin</b>  |  |   |  | 2. Date of Death<br>Month <b>December</b> Day <b>28</b> , Year <b>1997</b>  |  | 3. Time of Death<br><b>1:10 PM</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>5667 Gunpowder Road</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>White Marsh</b>  |  | 4c. County of Death<br><b>Baltimore</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-07-7404</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 24, 1907</b>  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10. Usual Residence of Decedent<br>10a. State <b>Maryland</b> 10b. County <b>Baltimore</b> 10c. City, Town or Location <b>White Marsh</b> 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 11. Merit Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:                                     |  |
| To Be Completed by Funeral Director                                  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>3rd grade</b> College (1-4 or 5+) <b></b>   |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Packing Dept. Personnel</b>   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Martin Anderson</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Bader</b>  |  | 19. Informant's Name/Relationship (Type, Print)<br><b>Elizabeth Betts (daughter)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5667 Gunpowder Road, White Marsh, MD 21162</b>                                     |  |
| Physician<br>/Medical<br>Examiner                                    | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gardens of Faith Cem.</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>   |  | 20d. Date<br><b>12/31/97</b>   |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236</b>   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Coronary Artery Disease</b><br>Due to (or as a consequence of):     |  | Approximate Interval Between Onset and Death   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23c. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Piece of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  | 28. Date of Injury (Month, Day, Year) 28b. Time of Injury <b>M</b> 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how Injury occurred |  |
| State Registrar  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D28177</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>12/29/97</b>   |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Mary E. Carroll MD 6801 Belair Rd Ba Ho MD 21206</b>   |  | 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>   |  | 32. Registrar's Signature<br>  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39817

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Leo Martin Mach

2. Date of Death  
Month Day Year  
December 24, 19973. Time of Death  
3:00 A.M.Funeral  
Director

4a. Facility Name (If not institution, give street and number)

4742 Homesdale Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

212-01-2284

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

93

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 27, 1904

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4742 Homesdale Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12th Grade

College (1-4or 5+)

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Plant Manager

16b. Kind of Business/Industry

Meat Company

17. Father's Name (First, Middle, Last)

Joseph Mach

18. Mother's Name (First, Middle, Maiden Sumama)

Josephine Zabawa

19a. Informant's Name/Relationship (Type, Print)

Henry Alton Fabiszak Jr. (Nephew)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

338 Essex Avenue, Baltimore, Maryland 21221

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sacred Heart of Jesus 12/27/97 Baltimore, Maryland

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Home Inc.  
3331 Brehms Lane, Baltimore, Maryland 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. HEAD AND NECK CANCER  
Due to (or as a consequence of):

Approximate interval Between Onset and Death

1 YEAR

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

William Skumfm MD

29c. License number

038459

29d. Date signed (Month, Day, Year)

12/26/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

William Skumfm 4940 Eastern Ave Baltimore, MD 21224

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

Julia Davidson-Hendall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

39818

|  |   |  |   |  |   |  |  |   |  |  |
|--|---|--|---|--|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>FLORENCE MARIE MAGLIDT</b>   |  |   |  | 2. Date of Death<br>Month <b>30</b> Day <b>DECEMBER</b> Year <b>1997</b>  |  |  |   | 3. Time of Death<br><b>12:04 AM</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Saint Joseph Medical Center</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Towson</b>   |  |  |   | 4c. County of Death<br><b>Baltimore</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-20-4762</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 29 1916</b> |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |
|  | Usual Residence of Decedent   |  |   |  |   |  |  |   |  |  |
| To Be Completed by Funeral Director                                  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Barkville</b>   |  |  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|  | 10a. Street and Number<br><b>9627 OAK Summit</b>  |  |   |  | 10f. Zip Code<br><b>21234</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>                |   |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8 yrs.</b> College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Assembler</b>   |  |  | 16b. Kind of Business/Industry<br><b>EMC corp.</b>                      |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Herbert Teal</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Bessie Shanklin</b>   |  |  |   |  |  |
| Physician<br>/Medical<br>Examiner                                    | 19a. Informant's Name/Relationship (Type, Print)<br><b>William Aumen</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11112 Lake Jackson DR. Manassas, VA. 20111</b>  |  |  |   |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garden of Faith</b>  |  | Date<br><b>Jan. 3 1998</b>                                 |   | 20c. Location - City or Town, State<br><b>Rosedale, Maryland</b>                                   |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Krista S. Wells</b>   |  |   |  | 22. Name and Address of Facility<br><b>Evans Funeral Chapel<br/>8800 Harford Rd. Baltimore, Maryland 21234</b>  |  |  |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b><br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |   |  |  |   |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |   |  |   |  |  |   |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DEHYDRATION</b>  |  |   |  |   |  |  |   |  |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |   |  |  |   |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>                            |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |  |
|  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28d. Describe how injury occurred   |  |  |   |  |  |
|  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |  |   |  |  |
| State<br>Registrar   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  | 29b. Signature and title of certifier<br><b>[Signature]</b>   |  | 29c. License number<br><b>D37254</b>                       |   | 29d. Date signed (Month, Day, Year)<br><b>12/30/97</b>   |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>BOON P. LIM, M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204</b>  |  |   |  |   |  |  |   |  |  |
|  | 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>   |  |   |  | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>  |  |  |   |  |  |
|  |   |  |   |  |   |  |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified immediately.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

THE UNIVERSITY OF CHICAGO  
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39819

Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68766  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |   |                                |  |   |  |  |
|---|--|---|--|---|--------------------------------|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Vernon FREUHERD Manger</b>   |  |   |  |   |                                | 2. Date of Death<br>Month <b>Dec</b> Day <b>19</b> Year <b>1997</b>              |   | 3. Time of Death<br><b>1230PM</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Lorien Nursing Home</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Columbia</b>   |                                | 4c. County of Death<br><b>Howard</b>   |   |  |  |
| 5. Social Security Number<br><b>216-09-3682</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>DEC 09, 1913</b>                       |   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>                                    |  |
| Usual Residence of Decedent   |  |   |  |   |                                |  |   |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>BALTIMORE</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE</b>   |                                |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>331 WESSLING CIRCLE</b>  |  |   |  | 10f. Zip Code<br><b>21228</b>   |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                   |   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12TH GRADE</b> College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>RETIRED</b>   |                                |  | 16b. Kind of Business/Industry<br><b>MEAT BUSINESS</b>                  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>WILLIAM H. MANGER</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MINNIE FREUHERD</b>   |                                |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>ALVIN S. MANGER (SON)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2202 BELLEVIEW RD - BALTIMORE, MD 21228</b>   |                                |  |   |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>LOUDON PARK CEMETERY</b>   |  | Date<br><b>12/26/97</b>   |                                | 20c. Location - City or Town, State<br><b>BALTIMORE</b>                          |   |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Spokie H. Shannon</b>   |  |   |  | 22. Name and Address of Facility<br><b>HUBBARD FUNERAL HOME INC.<br/>4107 WILKENS AVENUE-BALITMORE, MD 21229</b>  |                                |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>multisystem organ failure</b><br>Due to (or as a consequence of):<br>b. <b>sepsis</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Respiratory failure</b> |  |   |  |   |                                |  |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |   |  |   |                                |  |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |   |                                |  |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |   |                                |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |                                |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   | 28d. Describe how Injury occurred  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br><b>Gary Karkow</b>   |  | 29c. License number<br><b>041617</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>Dec 19, 1997</b>                       |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Gary Karkow 10805 Hickory Ridge Rd Columbia Md 21045</b>   |  |   |  |   |                                |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>   |  | 32. Registrar's Signature<br><b>John Davidson-Randall</b>   |  |   |                                |  |   |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 39820

Item: 6, per F.H G-755 1/7/98 reb

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EVELYN MARIE M CLARNEY

2. Date of Death

Month Day Year  
December 20, 1997

3. Time of Death

11:30 AM

4a. Facility Name (If not institution, give street and number)

CHARLESTOWN CARE CENTER

4b. City, Town, or Location of Death

CATONSVILLE

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

577-14-7577

6. Sex

F M ☒ F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
FEB 13, 1919

9. Birthplace (State or Foreign Country)

WASH., DC.

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

CATONSVILLE

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

719 MAIDEN CHOICE LANE - HR-212

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12TH GRADE

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOMEMAKING

17. Father's Name (First, Middle, Last)

SAMUEL S. JONES

18. Mother's Name (First, Middle, Maiden Surname)

MARGARET COOPER

19a. Informant's Name/Relationship (Type, Print)

JAMES J. McLARNEY, SR (HUSBAND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

719 MAIDEN CHOICE LA-HR-212-CATONSVILLE, MD 21228

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

20c. Location - City or Town, State

GATE OF HEAVEN CEMETERY 12/23/97 BALTIMORE

21. Signature of Funeral Service Licensee

Jackie D. Shannon

22. Name and Address of Facility

HUBBARD FUNERAL HOME INC.

4107 WILKENS AVENUE-BALTIMORE, MD 21229

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. END STAGE EMPHYSEMA

Due to (or as a consequence of):

Approximate interval Between Onset and Death

years

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RENAL INSUFFICIENCY

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No25. Was case referred to medical examiner?  
☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Bernard J. Lyle

29c. License number

D26473

29d. Date signed (Month, Day, Year)

DECEMBER 21, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

BERNARD F. LYLE, MD 711 MAIDEN CHOICE LANE, 21228

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

Name

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39821

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68768,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |                              |   |   |  |   |  |  |
|---|------------------------------|---|---|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>ALTA MILLER</b>  |                              |   |   | 2. Date of Death<br>Month <b>Dec</b> Day <b>28</b> Year <b>1997</b>  |   | 3. Time of Death<br><b>22:28</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>HOWARD COUNTY GENERAL HOSPITAL</b>   |                              |   |   | 4b. City, Town, or Location of Death<br><b>Columbia</b>  |   | 4c. County of Death<br><b>HOWARD</b>   |  |
| 5. Social Security Number<br><b>519-14-8221</b>   |                              | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.    | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.              | 8. Date of Birth (Month, Day, Year)<br><b>JUN 18, 1924</b>   |  |
| 9. Birthplace (State or Foreign Country)<br><b>Idaho</b>  |                              |   |   |  |   |  |  |
| Usual Residence of Decedent   |                              |   |   |  |   |  |  |
| 10a. State<br><b>MD</b>   | 10b. County<br><b>Howard</b> |   | 10c. City, Town or Location<br><b>Ellicott City</b> |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>3352 N. Chatham Road, Apt. C</b>   |                              |   | 10f. Zip Code<br><b>21042</b>                       |  | 10g. Citizen of What Country?<br><b>USA</b> |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |                              | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |                              | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Sales Clerk</b>   |   | 16b. Kind of Business/Industry<br><b>Womens Clothing</b>   |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Elra A. Herman</b>  |                              |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marion Larson</b>  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Harry B. Miller / son</b>  |                              |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1970 Woodstock Road Woodstock, MD 21163</b>  |   |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |                              | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc. 12/30/97</b>   |   | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>  |   |  |  |
| 21. Signature of Funeral Service Licensee<br><b>George E. MacNabb</b>   |                              | 22. Name and Address of Facility<br><b>Cremation Society of Md., Inc.<br/>299 Frederick Road Baltimore, MD 21228</b>  |   |  |   |  |  |
| 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                              | e. <b>PROBABIE CARDIAC ARRHYTHMIA</b><br>Due to (or as a consequence of):<br><b>COPD EXACERBATION</b><br>Due to (or as a consequence of):<br><b>ACUTE PANCREATITIS</b><br>Due to (or as a consequence of):<br><b>URINARY RETENTION</b>  |   | Approximate Interval Between Onset and Death<br><b>1 min</b><br><b>1 week</b><br><b>1 week</b><br><b>3 days</b>  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Major Depression, Osteoporosis,<br/>Multiple compression fractures<br/>of the spine</b>  |                              |   |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                              | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                              | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |                              | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 28d. Describe how Injury occurred   |                              | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |   |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                              |   |   |  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                       |                              | 29b. Signature and title of certifier<br><b>Dr. Kalikman MD</b>   |   | 29c. License number<br><b>D-50184</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>Dec. 29, 1997</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>ZHANNA KALIKMAN 9501 Old Annapolice Rd, Ellicott City</b>  |                              |   |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>   |                              | 32. Registrar's Signature<br><b>Julia Davidson-Rendall</b>  |   |  |   |  |  |

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39822

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last)

ANNIE

MYEROFF

2. Date of Death

Month Day Year  
December 25, 1997

3. Time of Death

5:45 AM

4a. Facility Name (If not institution, give street and number)

Hebrew Home Of Greater Washington

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

578-03-3508

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

99

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 28, 1898

9. Birthplace (State or Foreign Country)

Tennessee

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6121 Montrose Road

10f. Zip Code

20852

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Joseph Slabosky

18. Mother's Name (First, Middle, Maiden Surname)

Alice Chinsky

19a. Informant's Name/Relationship (Type, Print)

Jonathan Greenstein, Lawyer Nephew &

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3916 Fallstaff Road  
Baltimore, Maryland 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

12/26/1997  
King David Memorial Garden

20c. Location - City or Town, State

Falls Church, VA

21. Signature of Funeral Service Licensee

*Allen Smith* 000548

22. Name and Address of Facility

STEIN HEBREW MEMORIAL FUNERAL HOME, INC.  
232 CARROLL STREET, NW, WASHINGTON, DC 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. CEREBRAL THROMBOSIS, LEFT 1 MONTH

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA, Vascular

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☒ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*Dr. Star* STAR Physician

29c. License number

D 180 84

29d. Date signed (Month, Day, Year)

DECEMBER 25, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D.D. PATEL, M.D. 6121 MONTROSE RD, ROCKVILLE, MD 20852

31. Date (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

*John Davidson-Randall*

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



39823

DMMH 16 Rev 6/95

**Division of Vital Records, P.O. Box 68760,**  
to the Hospital or Attending Physician: The law requires that the death certificate be completed  
within 24 hours after death.  
to the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial transit

*[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page.]*

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39824

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Wilma Vtelka Nokes

2. Date of Death  
Month Day Year  
December 29, 19973. Time of Death  
11:15am

4a. Facility Name (If not institution, give street and number)

Plesant Living Nursing Home

4b. City, Town, or Location of Death

Edgewater

4c. County of Death

Anne Arundel

5. Social Security Number

215-18-2209

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 2, 1920

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

50 Bloomsbury Square

10f. Zip Code

21401

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Fred Green

18. Mother's Name (First, Middle, Maiden Surname)

Hattie Petinburn

19a. Informant's Name/Relationship (Type, Print)

Robert C. Nokes Sr. - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4 Virginia Ave. Edgewater, MD 21037

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Olivet Cemetery

Date

1/2/98

20c. Location - City or Town, State

Frederick, MD

21. Signature of Funeral Service Licensee

Robert C. Nokes Sr.

22. Name and Address of Facility

Hardesty Funeral Home, P.A.

12 Ridgely Ave. Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiopulmonary Arrest

Due to (or as a consequence of)

b. Metastatic squamous cell carcinoma

Due to (or as a consequence of)

c. Chronic obstructive pulmonary disease

Due to (or as a consequence of)

d. Anemia

Approximate Interval Between Onset and Death

1 hr

1 year

many years

1 year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner, as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Donna Chambers MD

29c. License number

D48101

29d. Date signed (Month, Day, Year)

12/29/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1833A Forest Dr Annapolis MD

Donna Chambers, MD

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

John Davidson-Randall

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the form to be filed in the State of Maryland.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39825

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ella Owens

2. Date of Death  
Month Day Year

December 26 1997

3. Time of Death

1545

4a. Facility Name (If not institution, give street and number)

DEATON UMMS

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

217-24-3071

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

MAY 5, 1909

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

N/A

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

255 S. Highland Avenue

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Packing

16b. Kind of Business/Industry

Maryland Workshop  
for the Blind

17. Father's Name (First, Middle, Last)

Charles Parr

18. Mother's Name (First, Middle, Maiden Surname)

Sarah White

19a. Informant's Name/Relationship (Type, Print)

Gwen Owens - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

255 S. Highland Ave., Balto., Md. 21224

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Baltimore Washington Crem.

Date

12/31/97

20c. Location - City or Town, State

Laurel, Mc.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gary L. Kaufman Funeral Home at Meadowridge MP  
7250 Washington Blvd., Elkridge, Md. 2107523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

Myocardial Infarction

Due to (or as a consequence of):

b.

ATRIAL FIBRILLATION / ANGINA PECTORIS

Due to (or as a consequence of):

c.

ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

MINUTES

+ 3 MONTHS

5+ YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA : HYPERTENSION;

HYPOTHYROIDISM : ARTHRITIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D01346

29d. Date signed (Month, Day, Year)

Dec. 29 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JAMES FLYNN DEATON HOSPITAL/HOME 611 S. CHARLES ST Baltimore Md 21230

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

State  
Registrar

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 39826

|   |  |   |  |  |  |   |  |  |
|---|--|---|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Thomas M Pfeiffer</b>                     |   |  |  | 2. Date of Death<br>Month <b>December</b> Day <b>25</b> Year <b>1997</b> |   | 3. Time of Death<br><b>11:00 PM</b>  |  |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>Church Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>            |   | 4c. County of Death<br><b>N/A</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>212-12-5922</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 12, 1921</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |
|   | Usual Residence of Decedent  |   |  |  |  |   |  |  |
| 10e. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Dundalk</b>  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>7251 Gough Street</b>  |  |   |  | 10f. Zip Code<br><b>21224</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>                                       |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11 Years</b> College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Painter</b>  |  | 16b. Kind of Business/Industry<br><b>State Government</b>                                   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Henry W. Pfeiffer</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Carrie Lyons</b>   |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Evelyn J. Pfeiffer/Wife</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7251 Gough Street Baltimore, MD 21224</b>  |  |   |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hilltop Service Corp.</b>  |  | Date<br><b>12/29/1997</b>  |  | 20c. Location - City or Town, State<br><b>Towson, MD</b>                                    |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Patricia M. Heming</b>  |  |   |  | 22. Name and Address of Facility<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.<br/>7922 Wise Ave. Dundalk, Maryland 21222</b>  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>e. <b>Pneumonia</b><br>Due to (or as a consequence of):<br>b. <b>Chronic Obstructive Pulmonary Disease</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.           |  |   |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>1 week</b><br><b>Years</b>  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>George E. Wicks M.D.</b>  |  | 29c. License number<br><b>D41365</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>December 25, 1997</b>                             |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>George E. Wicks M.D. 100 North Broadway 21231</b>  |  |   |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>   |  | 32. Registrar's Signature<br><b>John Frederick Randall</b>  |  |  |  |   |  |  |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

Physician  
/Medical  
Examiner

Funeral  
Director

NAME KNOWN TO PHYSICIAN  
Baltimore, Maryland 21215-0020  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be retained by the Maryland Department of Health and Mental Hygiene.  
Important: This form is not to be used for a "natural" or items 23a or 23b if any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21268-0760

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 39827

## Certificate of Death

Reg. No.

|  |  |  |   |  |  |  |  |  |  |  |
|--|--|--|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last) <i>Nina C. Perry</i>  |  |   |  | 2. Date of Death<br>Month Day Year<br><i>December 25, 1997</i>   |  |  |  | 3. Time of Death<br><i>10:40 AM</i>  |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br><i>101 E Lake Avenue</i>   |  |   |  | 4b. City, Town, or Location of Death<br><i>Baltimore</i>   |  |  |  | 4c. County of Death<br><i>NA</i>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><i>242-58-6324</i>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><i>78</i> Yrs.   |  | If Under 1 Year<br>Months Days   |  | If Under 24 Hrs.<br>Hours Min.   |  |
|  | 8. Date of Birth<br>(Month, Day, Year)<br><i>4-29-1919</i>   |  | 9. Birthplace (State or Foreign Country)<br><i>N.C.</i>   |  | 10a. State<br><i>MD</i>  |  | 10b. County<br><i>NA</i>   |  | 10c. City, Town or Location<br><i>Baltimore</i>  |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent  |  |   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |  |  |
|  | 10e. Street and Number<br><i>101 E. Lake Avenue</i>  |  |   |  | 10f. Zip Code<br><i>21212</i>  |  |  |  | 10g. Citizen of What Country?<br><i>U.S.A</i>  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>Black</i>  |  |
|  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12th grade</i>  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><i>Teacher</i>                        |  | 16b. Kind of Business/Industry<br><i>School</i>  |  |  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><i>Alexander Clay</i>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Hottie Holloway</i>  |  |  |  |  |  |
| Physician<br>/Medical<br>Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><i>Acres R. Perry - Son</i>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>101 Lake Avenue Baltimore, MD 21212</i>  |  |  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Perry Family Plot</i>  |  | 20c. Date<br><i>12-29-97</i>   |  | 20d. Location - City or Town, State<br><i>Ashokle, N.C.</i>                          |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Sola March</i>   |  |   |  | 22. Name and Address of Facility<br><i>March F.H.<br/>4300 Wabash Avenue Baltimore, MD 21215</i>   |  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><i>Pancreatic Cancer</i>  |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death<br><i>6 months</i>  |  |
|  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |   |  |  |  |  |  |  |  |
| Division of Vital Records, P.O. Box 68760<br>Baltimore, Maryland 21215-0020            | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|  |  |  |   |  |  |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|  |  |  |   |  |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |  |  |  |  |
| State<br>Registrar   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  | 29b. Signature and title of certifier<br><i>Paul Celano, M.D.</i>  |  |  |  | 29c. License number<br><i>D30929</i>   |  |
|  | 29d. Date signed (Month, Day, Year)<br><i>12/26/97</i>   |  |   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>PAUL CELANO, MD 6069 N. Charles ST, BALTIMORE, MD 21204</i>   |  |  |  |  |  |
|  | 31. Date filed (Month, Day, Year)<br><i>DEC 31 1997</i>  |  |   |  | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

87 39828

|  |   |   |   |   |  |   |  |  |   |  |   |  |  |  |  |  |  |
|--|---|---|---|---|--|---|--|--|---|--|---|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Frances Vincenza Pinelli</b>   |   |   |   | 2. Date of Death<br>Month <b>December</b> Day <b>28</b> , Year <b>1997</b>   |   | 3. Time of Death<br><b>10:10 AM</b>  |  |   |  |   |  |  |  |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Dulaney Towson Health Care Center</b>  |   |   |   | 4b. City, Town, or Location of Death<br><b>Towson</b>  |   | 4c. County of Death<br><b>Baltimore</b>  |  |   |  |   |  |  |  |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>214-36-8244</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>99</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 25, 1898</b>                                |  | 9. Birthplace (State or Foreign Country)<br><b>Italy</b> |   |  |   |  |  |  |  |  |  |
|  | Usual Residence of Decedent   |   |   |   |  |   |  |  |   |  |   |  |  |  |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Baltimore</b>   |   | 10c. City, Town or Location<br><b>Baltimore</b>  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |   |  |  |  |  |  |  |
|  | 10e. Street and Number<br><b>4309 Camellia Road</b>   |   |   |   | 10f. Zip Code<br><b>21236</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |   |  |   |  |  |  |  |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |  |   |  |  |  |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Unknown</b>   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b> |  | 16b. Kind of Business/Industry<br><b>Own Home</b>   |  |  |   |  |   |  |  |  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>John Currao</b>   |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Francezica Giufrula</b>  |   |  |  |   |  |   |  |  |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Nancy Tur (daughter)</b>   |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9417 Kilbride Ct., Perry Hall, MD 21128</b>  |   |  |  |   |  |   |  |  |  |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parkwood Cemetery</b>  |   | Data<br><b>12/31/97</b>  |   | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>  |  |   |  |   |  |  |  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>   |   |   |   | 22. Name and Address of Facility<br><b>Schimunek Funeral Homes, Inc.<br/>9705 Belair Rd., Baltimore, MD 21236</b>  |   |  |  |   |  |   |  |  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |   |  |   |  |  |   |  |   |  |  |  |  |  |  |
|  | <table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>Carcinoma of Colon</b><br/>Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death<br/><b>months</b></td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. <br/>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c. <br/>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d. <br/>Due to (or as a consequence of):</td> <td></td> </tr> </table> |   |   |   |  |   |  |  | Immediate Cause (Final disease or condition resulting in death) | a. <b>Carcinoma of Colon</b><br>Due to (or as a consequence of): | Approximate Interval Between Onset and Death<br><b>months</b> | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b.<br>Due to (or as a consequence of): |  | c.<br>Due to (or as a consequence of): |  | d.<br>Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death)  | a. <b>Carcinoma of Colon</b><br>Due to (or as a consequence of):  | Approximate Interval Between Onset and Death<br><b>months</b>   |   |   |  |   |  |  |   |  |   |  |  |  |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | b.<br>Due to (or as a consequence of):  |   |   |   |  |   |  |  |   |  |   |  |  |  |  |  |  |
|  | c.<br>Due to (or as a consequence of):  |   |   |   |  |   |  |  |   |  |   |  |  |  |  |  |  |
|  | d.<br>Due to (or as a consequence of):  |   |   |   |  |   |  |  |   |  |   |  |  |  |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Alzheimer's Dementia</b>   |   |   |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |  |   |  |  |  |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |   |  |  |   |  |   |  |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |   |  |  |   |  |   |  |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred                        |   |  |   |  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br>   |   | 29c. License number<br><b>D25234</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>December 29, 1997</b>                             |  |  |   |  |   |  |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ROBERT AMMLING MD 7600 Osler Drive SUITE TOWSON, MD 21204</b>   |   |   |   |   |  |   |  |  |   |  |   |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>  |   | 32. Registrar's Signature<br>   |   |   |  |   |  |  |   |  |   |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39829

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Herman V. Pitt

2. Date of Death

Month

Day

Year

December

25

1997

3. Time of Death

3:00PM

4e. Facility Name (If not institution, give street and number)

12800 Bridlepath Rd.

4b. City, Town, or Location of Death

Reisterstown

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

215-01-6486

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 30 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Reisterstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12800 Bridlepath Rd.

10f. Zip Code

21136

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 yrs.

College (1-4 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

President

16b. Kind of Business/Industry

Specialty die &amp; container corp.

17. Father's Name (First, Middle, Last)

Herman B. Pitt

18. Mother's Name (First, Middle, Maiden Surname)

Regina Scheindler

19e. Informant's Name/Relationship (Type, Print)

Eileen Clarke

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12800 Bridlepath Rd. Reisterstown, Md 21136

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holy Redeemer Cemetery

Date

Dec 29 1997

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Krista S. Wells

22. Name and Address of Facility

Evans Funeral Chapel  
2325 York Rd Timonium, Maryland 21093

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Due to (or as a consequence of):

HTN

b.

Due to (or as a consequence of):

dyslipidemia

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

N/A

28b. Time of Injury

N/A M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

N/A

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

N/A

28f. Location (Street and Number or Rural Route Number, City or Town, State)

N/A

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M. Small

29c. License number

D35304

29d. Date signed (Month, Day, Year)

12/30/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

3411 Bank St., Baltimore, MD, 21224

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39830

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GEORGE W. PARKER, JR.

2. Date of Death

Month Day Year  
December 25 1997

3. Time of Death

12:30 PM

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL Hospital

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

Funeral  
Director

5. Social Security Number

220-18-4278

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71 Yrs.

8. Date of Birth

Month Day Year

March 21, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1323 Howard Rd.

10f. Zip Code

21060

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WW 2

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

Collega (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Electrician

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

George W. Parker, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Herr

19a. Informant's Name/Relationship (Type, Print)

Judith A. Byrnie / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

913 Merriweather Way, Severn, Maryland 21144

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Crownsville MD Vet. Cem.

Date

Dec. 29

20c. Location - City or Town, State

Crownsville, Maryland

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Kirkley-Ruddick Funeral Home, P.A.

421 Crain Hwy., S.E., Glen Burnie, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Septic shock

Due to (or as a consequence of):

b. gangrene

Due to (or as a consequence of):

c. peripheral vascular disease

Due to (or as a consequence of):

d. Diabetes mellitus

Approximate Interval Between Onset and Death

6 hours

1 week

years

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic renal failure on dialysis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending Investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician

2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]* STUART JACOBS MD

29c. License number

022483

29d. Date signed (Month, Day, Year)

12/25/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STUART JACOBS MD North Arundel Hospital Glen Burnie, Md. 21061

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

*[Signature]* Julia Davidson-Randall

State Registrar

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Parker, George  
Baltimore, Maryland 21215-0020



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39831

Physician  
/Medical  
Examiner

Funeral  
Director

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>EVELYN M. PURNELL</b>  |  |  |  | 2. Date of Death<br>Month Day Year<br><b>DECEMBER 29, 1997</b>   |  | 3. Time of Death<br><b>5:45 PM</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>UNIVERSITY OF MARYLAND MEDICAL CENTER</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>N/A</b>  |  |
| 5. Social Security Number<br><b>262-40-9373</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>56</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>OCT. 25, 1941</b>  |  |
| 9. Birthplace (State or Foreign Country)<br><b>GEORGIA</b>  |  |  |  |  |  |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>N/A</b>  |  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>1816 WILKENS AVENUE</b>  |  |  |  | 10f. Zip Code<br><b>21223</b>  |  | 10g. Citizen of What Country?<br><b>UNITED STATES</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+) <b></b>   |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>  |  | 16b. Kind of Business/Industry<br><b>HOME</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>JAMES W. SPILLERS</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MINNIE L. MCGINNIS</b>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>GERALD PURNELL/HUSBAND</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1816 WILKENS AVENUE BALTIMORE, MD 21223</b>  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>LOUDON PARK MAUSOLEUM</b>   |  | Date<br><b>1/2/98</b>  |  | 20c. Location - City or Town, State<br><b>BALTIMORE, MD</b>  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |  |  | 22. Name and Address of Facility<br><b>LOUDON PARK FUNERAL HOME</b><br><b>3620 WILKENS AVENUE BALTIMORE, MD 21229</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b><br>Due to (or as a consequence of):<br><br>b. <b>MALNUTRITION</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|   |  |  |  |  |  | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|   |  |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28d. Describe how Injury occurred  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br>  |  |  |  | 29c. License number<br><b>D31993</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>DECEMBER 30, 1997</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Edward Bolgiano, M.D. University of MD Medical Ctr., Baltimore, MD</b>   |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>   |  |  |  | 32. Registrar's Signature<br>   |  |  |  |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be prepared within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

37 39832

Amended #1 per MEO G754 12/31/97 EW

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

PATRICIA

A.

PRICE

2. Date of Death

Month

Day

Year

Dec

12

97

3. Time of Death

2:15pm

4a. Facility Name (If not institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George

Funeral  
Director

5. Social Security Number

223-82-8505

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

47

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

Oct. 05 1950

9. Birthplace (State or Foreign Country)

Va.

Usual Residence of Decedent

10a. State

Md.

10b. County

Prince George

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4 Woodland Ct.

10f. Zip Code

20707

10g. Citizen of What Country?

USA.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John Madison

18. Mother's Name (First, Middle, Maiden Surname)

Rose Lee Falkner

19a. Informant's Name/Relationship (Type, Print)

Tracy Fleming

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12309 Rochester Dr., Fairfax, Va. 22030

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fairfax Crematory

Date

12/17/97

20c. Location - City or Town, State

Fairfax, Va.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Everly Funeral Home

10565 Main St., Fairfax, Va. 22030

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Upper Gastrointestinal bleeding

Due to (or as a consequence of):

b. Cirrhosis of liver

Due to (or as a consequence of):

c. Hepatitis C infection

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

30 min

1 1/2 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Bilateral Pneumonia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 24721

29d. Date signed (Month, Day, Year)

12/12/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

SYDNEY SANDOZ

14800, 4th Street

LAUREL, MD 20707

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39833

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BENJAMIN PHILIPSON

2. Date of Death

Month Day Year  
December 26 1997

3. Time of Death

3:30 AM

4a. Facility Name (If not institution, give street and number)

CHARLESTOWN NURSING HOME

4b. City, Town, or Location of Death

CATONSVILLE

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

107-01-9674

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JULY 7, 1914

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10e. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

13 DIAMOND CREST COURT

10f. Zip Code

21209

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

STOCKBROKER

16b. Kind of Business/Industry

SECURITIES

17. Father's Name (First, Middle, Last)

ABRAHAM

WOLF

PHILIPSON

18. Mother's Name (First, Middle, Maiden Surname)

LEIBA

BOUER

19a. Informant's Name/Relationship (Type, Print)

DR. JONATHAN PHILIPSON / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13 DIAMOND CREST COURT BALTIMORE, MD 21209

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

EVERGREEN

Date

12/28/97 TUCSON, ARIZONA

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Jay Alan Levin

22. Name and Address of Facility

Sol Levinson &amp; Bros., Inc.

8900 Reisterstown Road Pikesville, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. END STAGE ALZHEIMER'S DISEASE

Approximate Interval Between Onset and Death

1 MONTHS

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Bernard J. Kofner

29c. License number

026477

29d. Date signed (Month, Day, Year)

December 26, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BERNARD F KOFNER, MD, 711 MAIDEN CHOICE LANE, BALTO, MD. 21228

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

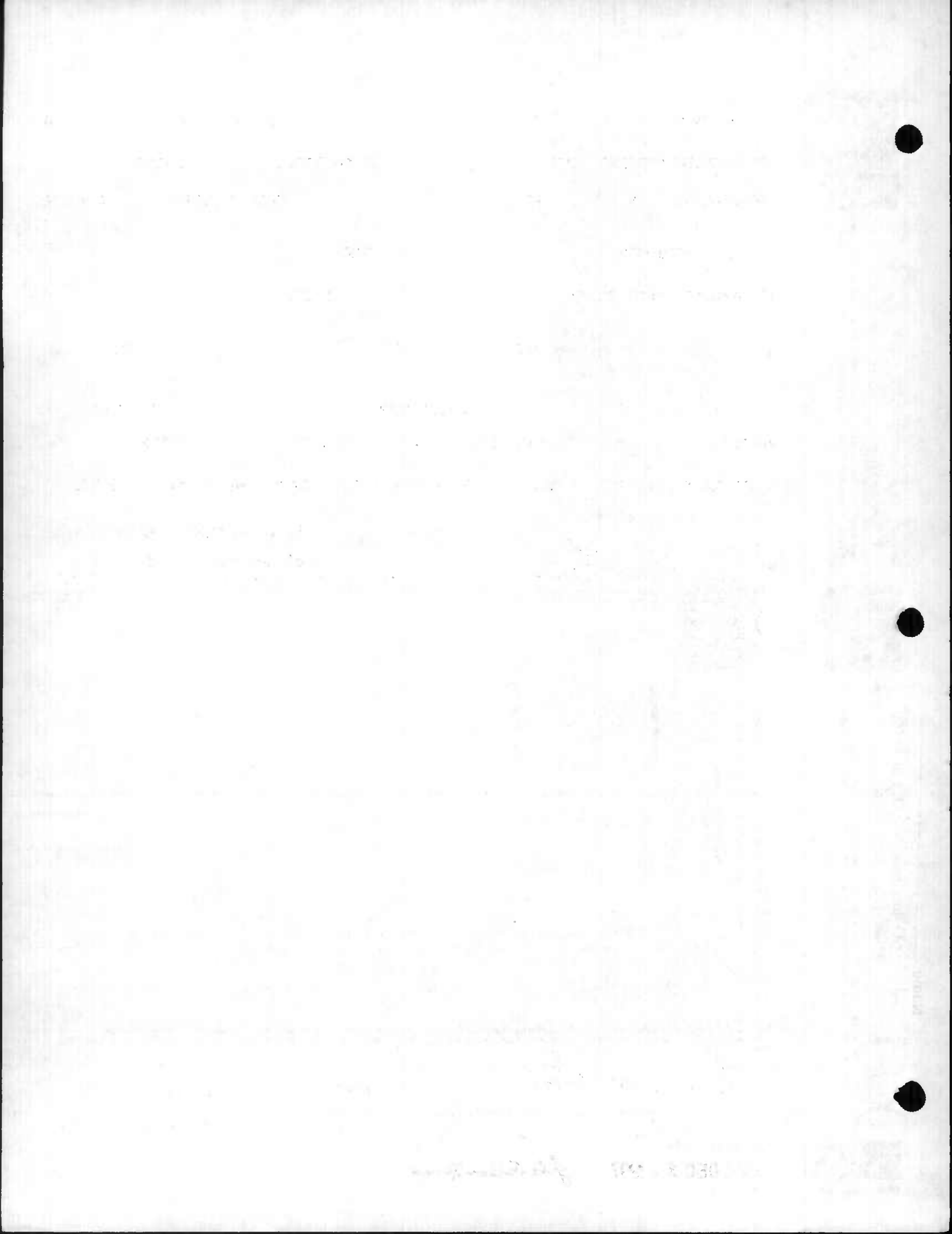
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Name: Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



97 39834

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ABRAHAM</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>December</b> DAY <b>26</b> YEAR <b>1997</b>  |  |  |  | 3. TIME OF DEATH<br><b>7:00 A</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-03-5766</b>   |  | 5. SEX<br><b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>87</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>DEC. 19, 1910</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>MD</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>MILFORD MANOR NURSING HOME</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>   |  |  |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>  |  |
| RESIDENCE OF DECEDENT   |  |   |  |   |  |  |  |  |  |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>N/A</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>6810 PARK HEIGHTS AVENUE #308</b>  |  |   |  | 10f. ZIP CODE<br><b>21215</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |  |
| 11. MARITAL STATUS<br><b>3</b> <input checked="" type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES <b>X</b> |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                            |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>X</b>  |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>PAINT MIXER</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>PAINT COMPANY</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>LOUIS PACHINO</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>HILDA MENDELOFF</b>   |  |  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>SONDRA SCHERR / NIECE</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1008 FLAGTREE LANE BALTIMORE, MD 21208</b>  |  |  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>ANSHE EMUNAH AITZ CHAIM 12-28-97 BALTIMORE, MD</b>   |  | 20c. LOCATION — City or Town, State   |  |  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Michael Bruga</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Sol Levinson &amp; Bros., Inc.<br/>8900 Reisterstown Road Pikesville, MD 21208</b>   |  |  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Atherosclerotic cardiovascular disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>b. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>c. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>d. DUE TO (OR AS A CONSEQUENCE OF):</b> |  |   |  |   |  |  |  | Approximate Interval Between Onset and Death<br><b>&gt;2 years</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO   |  |   |  |   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA<br>OTHER: <b>4</b> <input checked="" type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify) |  |
| 27. MANNER OF DEATH<br><b>1</b> <input type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation<br><b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined<br><b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Davidson</i> MD   |  |   |  | 29c. LICENSE NUMBER<br><b>D15872</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Dec 26 1997</b>  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Harold B. Bub 28 March 50 21136</b>   |  |   |  |   |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 31 1997</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39835

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Larene Pazourek

2. Date of Death

Month December Day 14, Year 1997

3. Time of Death

1331

4a. Facility Name (If not institution, give street and number)

Atlantic General Hospital

4b. City, Town, or Location of Death

Berlin

4c. County of Death

Worcester

Funeral  
Director

5. Social Security Number

171-28-8719

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 27, 1917

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1507 Riverside Drive

10f. Zip Code

21801

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Hairdresser

16b. Kind of Business/Industry

Beauty Salon

17. Father's Name (First, Middle, Last)

Elder Joseph Bolen

18. Mother's Name (First, Middle, Maiden Surname)

Rebecca Grace Blackburn

19a. Informant's Name/Relationship (Type, Print)

Edward Pazourek/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1507 Riverside Drive, Salisbury, Maryland 21801

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*Ronald S. Wade*

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore, Street = Baltimore, Maryland 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ASCVD

Due to (or as a consequence of):

b. Sepsis

Due to (or as a consequence of):

c. Malnutrition

Due to (or as a consequence of):

d. Electrolyte Imbalance

Approximate Interval Between Onset and Death

Years

Weeks

Months

Days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Deep Vein Thrombophlebitis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home

5 ☐ Residence

8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

D28769

29d. Date signed (Month, Day, Year)

12/14/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

NICHOLAS N. BORODULIA, M.D. 1209 Ocean Highway, Fenwick Island, DE 19744

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

*[Signature]*

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39836

|  |  |  |   |  |  |                                |  |   |
|--|--|--|---|--|--|--------------------------------|--|---|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><u>Pamela P. Quandt</u>  |  |   |  | 2. Date of Death<br>Month <u>December</u> Day <u>28</u> Year <u>1997</u>   |                                | 3. Time of Death<br><u>6:18 PM</u>   |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><u>University of Maryland Medical System</u>   |  |   |  | 4b. City, Town, or Location of Death<br><u>Baltimore</u>   |                                | 4c. County of Death<br><u>Baltimore City</u>   |   |
| Funeral<br>Director  | 5. Social Security Number<br><u>212-60-0229</u>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><u>44</u> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth<br>(Month, Day, Year)<br><u>MAY 1, 1953</u>   | 9. Birthplace (State or Foreign Country)<br><u>Maryland</u> |
|  | Usual Residence of Decedent  |  |   |  |  |                                |  |   |
| To Be Completed by Funeral Director                                  | 10a. State<br><u>MD.</u>   |  | 10b. County<br><u>Baltimore</u>   |  | 10c. City, Town or Location<br><u>Parkville</u>  |                                | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |
|  | 10e. Street and Number<br><u>36 Tommy TRUE COURT</u>   |  |   |  | 10f. Zip Code<br><u>21234</u>  |                                | 10g. Citizen of What Country?<br><u>USA</u>  |   |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>WHITE</u>  |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Housewife</u>   |  | 16b. Kind of Business/Industry<br><u>Home</u>  |                                |  |   |
| To Be Completed by Physician/Medical Examiner                        | 17. Father's Name (First, Middle, Last)<br><u>George PAPEL, SR</u>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>DOROTHY Shattuck</u>   |                                |  |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><u>BRUCE QUANDT / HUSBAND</u>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>36 Tommy TRUE Ct Baltimore, MD 21234</u>   |                                |  |   |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Green Mount Cemetery</u>   |  | Date<br><u>Dec 30 1997</u>   |                                | 20c. Location - City or Town, State<br><u>Baltimore, Maryland</u>  |   |
|  | 21. Signature of Funeral Service Licensee<br><u>Robert W. Groves Jr.</u>   |  |   |  | 22. Name and Address of Facility<br><u>EVANS CHAPEL of Memories 8800 Harford Rd Balto. Md.</u>   |                                |  |   |
| Physician<br>/Medical<br>Examiner                                    | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <u>Sepsis</u><br>Due to (or as a consequence of):<br><br>b. <u>Renal Failure</u><br>Due to (or as a consequence of):<br><br>c. <u>Hepatic Failure</u><br>Due to (or as a consequence of):<br><br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |                                | Approximate Interval Between Onset and Death   |   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |                                |  |   |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |   |  |  |                                | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |
|  |  |  |   |  |  |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |                                |  |   |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |
|  |  |  | 28d. Describe how injury occurred   |  |  |                                | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |   |
|  |  |  | 28f. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |                                |  |   |
| State Registrar  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |                                |  |   |
|  | 29b. Signature and title of certifier<br><u>Stephen L. Lin, M.D.</u>   |  |   |  | 29c. License number<br><u>P09748</u>   |                                | 29d. Date signed (Month, Day, Year)<br><u>December 28 1997</u>   |   |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>22 S. Greene St. Department of Medicine Baltimore, MD 21201</u>   |  |   |  |  |                                |  |   |
|  | 31. Date filed (Month, Day, Year)<br><u>DEC 31 1997</u>  |  | 32. Registrar's Signature<br><u>Julia Davidson-Randall</u>  |  |  |                                |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Norma Regina Rose

2. Date of Death

Month Day Year  
December 28, 1997

3. Time of Death

11 A.M.

4a. Facility Name (If not institution, give street and number)

1004 Adcock Road

4b. City, Town, or Location of Death

Lutherville

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

213-36-4873

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

60

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Aug. 30, 1937

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Lutherville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1004 Adcock Road

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Michele DiMartino

18. Mother's Name (First, Middle, Maiden Surname)

Grace Toskes

19a. Informant's Name/Relationship (Type, Print)

Mr. W. Louis Rose (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1004 Adcock Road Lutherville, Maryland 21093

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Parkwood Cemetery

Date

12/31/97

20c. Location - City or Town, State

Baltimore Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Towson, Md. 21204

Ruck Towson Funeral Home, Inc. 1050 York Road

23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

e. Metastatic Neuroendocrine Tumor of the Pancreas

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
Investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicidal ☐  
☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D17207

29d. Date signed (Month, Day, Year)

December 29, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Baltimore, Md.

David S. Ettinger, M.D. The Johns Hopkins Oncology Center 600 N. Wolfe St.

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SCARLETT

REED

2. Date of Death  
Month Day Year

DECEMBER 27, 1997

3. Time of Death

10:05am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Stella Maris

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

N/A

5. Social Security Number

220-64-3541

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

42 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

9-23-55

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1326 W. Lafayette Ave.

10f. Zip Code

21217

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Afro American

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

8

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Parking Lot Attendant

16b. Kind of Business/Industry

Park America

17. Father's Name (First, Middle, Last)

Hazel Haywood Reed

18. Mother's Name (First, Middle, Maiden Surname)

Robbie Ross Davis

19a. Informant's Name/Relationship (Type, Print)

Mr. Christopher Davis

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1326 W. Lafayette Ave. Baltimore Md 21217

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion Cem

Date

12/31/97

20c. Location - City or Town, State

BALTO. Co. Md

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph F. Russ Funeral Home  
2225 W. North Ave. Baltimore Md 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CERVICAL CANCER

Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Dua to (or as a consequence of):

c. Dua to (or as a consequence of):

d. Dua to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. Penelope Edwards

29c. License number

D44128

29d. Date signed (Month, Day, Year)

12-29-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. PENELOPE EDWARDS, 2300 DULANEY VALLEY RD., TIMONIUM, MD 21093

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39839

|   |  |  |  |  |   |  |   |  |
|---|--|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>William T. Russell, Jr.</b>   |  |  |  | 2. Date of Death<br>Month <b>DEC.</b> Day <b>28</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>6:45 a.m.</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Union Memorial Hospital</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>   |  | 4c. County of Death<br><b>N/A</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>215-22-3066</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>70</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>June 13, 1927</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore City</b>  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  | 10e. Street and Number<br><b>1428 Decatur Street</b>  |  | 10f. Zip Code<br><b>21230</b>   |  |
|   | 10g. Citizen of What Country?<br><b>United States</b>  |  |  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>WWII</b><br>If Yes, Give Year or Dates: <b>2/9/46-6/28/47</b> |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9th</b> College (14 or 5+) <b>N/A</b>   |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Warehouse Worker</b>   |  |  |  | 16b. Kind of Business/Industry<br><b>Distribution</b>   |  |   |  |
| Physician<br>/Medical<br>Examiner             | 17. Father's Name (First, Middle, Last)<br><b>William T. Russell, Sr.</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Irma J. Vettters</b>  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Joyce E. Russell / Wife</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1428 Decatur Street, Baltimore Maryland 21230</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Crownsville Veterans Cemetery, December 30, 1997 Crownsville, Maryland</b>   |  | 20c. Location - City or Town, State   |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Victor P. Doda, Jr.</b>  |  |  |  | 22. Name and Address of Facility<br><b>Charles L. Stevens Funeral Home, Inc.<br/>1501 East Port Avenue, Baltimore Maryland 21230</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. ASPIRATION PNEUMONITIS</b><br>Due to (or as a consequence of):<br><b>b. PSEUDOMEMBRANOUS COLITIS</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |  |  | Approximate Interval Between Onset and Death<br><b>20 hrs</b><br><b>14 days</b>   |  | Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last                            |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.<br><b>CORONARY ARTERY DISEASE</b><br><b>HYPERTENSION</b>  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  |  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  |
|   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 28d. Describe how injury occurred   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |  |  | 29b. Signature and title of certifier<br><b>Michael K. Juchewski, M.D.</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29c. License number<br><b>AT 243 8946</b>  |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>Dec 28, 1997</b>  |  |   |  |
|   | 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br><b>201 E. University Parkway, Baltimore, Md. 21218</b>   |  |  |  | 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature<br><b>Julia Davidson-Rendell</b>   |  |  |  | 33. Registrar's Title<br><b>Registrar</b>   |  |   |  |
|   | 34. Registrar's Office<br><b>State Registrar</b>   |  |  |  | 35. Registrar's Address<br><b>State Registrar</b>   |  |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39840

|   |   |  |   |   |  |                                 |  |   |   |  |  |
|---|---|--|---|---|--|---------------------------------|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ALBERTA ROBINSON</b>   |  |   |   | 2. Date of Death<br>Month <b>12</b> Day <b>27</b> Year <b>97</b>   |                                 | 3. Time of Death<br><b>10PM</b>  |   |   |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Maryland General Hospital 827 LINDEN AVE</b>   |  |   |   | 4b. City, Town, or Location of Death<br><b>Baltimore-MD</b>  |                                 | 4c. County of Death<br><b>Baltimore</b>  |   |   |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>020-48-6171</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>102</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 23, 1895</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>Md.</b>  |   |  |  |
|   | Usual Residence of Decedent   |  |   |   |  |                                 |  |   |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Md.</b>  |  | 10b. County<br><b>n/a</b>   |   | 10c. City, Town or Location<br><b>Baltimore</b>  |                                 | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |   |  |  |
|   | 10e. Street and Number<br><b>2512 McCulloh Street</b>   |  |   |   | 10f. Zip Code<br><b>21217</b>  |                                 | 10g. Citizen of What Country?<br><b>USA</b>  |   |   |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                 | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |   |   |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6th grade</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Domestic</b>                      |   | 16b. Kind of Business/Industry<br><b>Private Families</b>  |                                 |  |   |   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>William Brooks</b>  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Annie unknown</b>  |                                 |  |   |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print) <b>friend</b><br><b>Reba Matthews</b>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2511 McCulloh Street Baltimore, Md. 21217</b>  |                                 |  |   |   |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Baltimore National</b>   |   | Date<br><b>Jan. 2</b>  |                                 | 20c. Location - City or Town, State<br><b>Baltimore, Md.</b>                                   |   |   |  |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  |   |   | 22. Name and Address of Facility<br><b>Nutter Funeral Homes, Inc.<br/>2501 Gwynns Falls PKWY Baltimore, Md. 21216</b>  |                                 |  |   |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Myocardial Infarction</b><br>Due to (or as a consequence of):<br><b>b. Atherosclerotic Coronary Vascular Disease</b><br>Due to (or as a consequence of):<br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |   |   |  |                                 |  |   | Approximate Interval Between Onset and Death<br><b>24 hours.</b>  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  |                                 |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |
|   |   |  |   |   |  |                                 |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                 |  |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   |  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b> |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No           |   | 28d. Describe how Injury occurred  |  |
|   |   |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |                                 |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                          |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   | 29b. Signature and title of certifier<br>  |  |                                 |  | 29c. License number<br><b>89276</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>12/27/97</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Rupinder Singh, M.D. c/o Maryland General Hospital</b>   |   |  |   |   |  |                                 |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>   |   |  |   | 32. Registrar's Signature<br>  |  |                                 |  |   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39841

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mildred H. Rawlings

2. Date of Death

Month  
12Day  
24Year  
97

3. Time of Death

09:25PM

4a. Facility Name (If not institution, give street and number)

University Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

n/a

Funeral  
Director

5. Social Security Number

214-30-2602 A

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

67

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
July 5, 1930

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State  
Md.

10b. County

Baltimore

10c. City, Town or Location

Randallstown

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

3 Dell Court

10f. Zip Code

21244

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Educator/ Retired

16b. Kind of Business/Industry

Baltimore City

Dept. of Education

17. Father's Name (First, Middle, Last)

Stanley E. Hall

18. Mother's Name (First, Middle, Maiden Surname)

Ethel M. Berry

19a. Informant's Name/Relationship (Type, Print)

William M. Rawlings

husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3 Dell Court Randallstown, Md. 21244

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Woodlawn Cemetery

Date

Dec.30

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

Nutter E. Nutter

22. Name and Address of Facility

Nutter Funeral Homes, Inc.

2501 Gwynns Falls PKWY Baltimore, Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Metastatic moderately differentiated lung adenocarcinoma years

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

26. Place of Death (Check only one)

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Kennita R. Carter MD

29c. License number

D09728

29d. Date signed (Month, Day, Year)

12/24/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Kennita R. Carter, M.D. 22 S. Greene St. Baltimore MD 21201

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39842

|  |  |   |  |  |  |  |   |  |  |
|--|--|---|--|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>CARL WILLIAM RADFORD</b>  |   |  |  | 2. Date of Death<br>Month Day Year<br><b>DEC 16 1997</b> |  | 3. Time of Death<br><b>1625pm</b>                           |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>NATIONAL NAVAL MEDICAL CENTER, BETHESDA</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>BETHESDA</b>  |  | 4c. County of Death<br><b>MONTGOMERY CO.</b>                |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>235-40-5193</b>  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>68</b> Yrs.         |  | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 13, 1929</b> |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Fairmont, W. Va.</b>  |   | 10a. State<br><b>De.</b>   |  | 10b. County<br><b>Kent</b>                               |  | 10c. City, Town or Location<br><b>Felton</b>                |  |  |
| Usual Residence of Decedent  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>15 Pratts Branch Rd.</b>  |  | 10f. Zip Code<br><b>19943</b>  |   | 10g. Citizen of What Country?<br><b>U.S.</b>   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever In U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1952 To 1979</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>                  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>U.S.A.F. Ret.</b>  |  | 16b. Kind of Business/Industry<br><b>U.S. Govmt.</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>Orva William Redford</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Dulcie Curry</b>   |   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Willa L. Drake Radford (wife)</b>   |  |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>15 Pratts Branch Rd. Felton, De. 19943</b>   |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Delaware Veterans Memorial Cem. Bear, De.</b>   |  | 20c. Location - City or Town, State<br><b>12-22-1997</b>   |   | 21. Signature of Funeral Service Licensee<br><i>Thomas R. Reader</i>   |  |
| 22. Name and Address of Facility<br><b>19901</b>   |  | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>PULMONARY FIBROSIS / PULMONARY EMBOLUS</b>  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how Injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><b>J. M. MCCURLEY, LCDR, MC, USNR</b>   |  |
| 29c. License number<br><b>00052824 (MD)</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>Dec 18, 1997</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>NATIONAL NAVAL MEDICAL CENTER<br/>BETHESDA, MD 20889-5600</b>   |  | 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>  |   | 32. Registrar's Signature<br><i>John Davidson</i>  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

15

State  
Registrar

Handwritten text, possibly a signature or date, including "1942" and "1943".

Handwritten text at the bottom of the page, including "1942" and "1943".

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

WILLIAM

State of Maryland / Department of Health and Mental Hygiene

ROTH items: 23a part I, 27 per MEO G-755 1/28/98 dh

Certificate of Death

Reg. No.

97 39843

|  |   |  |  |  |   |  |  |  |
|--|---|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>William Henry Roth III                        |  |  |  | 2. Date of Death<br>Month Day Year<br>DECEMBER 25, 1997 |  | 3. Time of Death<br>8:53 P.M.                            |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>GOOD SAMARITAN HOSPITAL |  |  |  | 4b. City, Town, or Location of Death<br>BALTIMORE       |  | 4c. County of Death<br>Baltimore City                    |  |
| Funeral<br>Director  | 5. Social Security Number<br>213-30-4283  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 7. Age (in yrs. last birthday)<br>65 Yrs.               |  | 8. Date of Birth (Month, Day, Year)<br>November 16, 1932 |  |
|  | 9. Birthplace (State or Foreign Country)<br>Baltimore, Maryland                           |  | 10a. State<br>Maryland   |  | 10b. County<br>Baltimore                                |  | 10c. City, Town or Location<br>Baltimore County          |  |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br>5003 King Avenue   |  | 10f. Zip Code<br>21237   |   | 10g. Citizen of What Country?<br>U.S.A.  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1953-1955  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12<br>College (1-4 or 5+) N/A   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Unemployed  |  | 16b. Kind of Business/Industry<br>Unemployed   |   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>William Henry Roth, Jr.   |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Ida Mae Wheeler   |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Arlene C. Roth (Wife)  |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5003 King Avenue Baltimore, Maryland 21237  |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Parkwood Cemetery December 29, 1997  |   | 20c. Location - City or Town, State<br>Baltimore, Maryland   |  |  |
| 21. Signature of Funeral Service Licensee<br>Theodore M. King  |   |  |  | 22. Name and Address of Facility<br>Lassahn Funeral Home, Inc.<br>7401 Belair Road Baltimore, Maryland 21236-4625  |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |  |  |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |  |
|  |   |  |  |  |   | 24e. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |
|  |   |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |
|  |   | 28d. Describe how injury occurred  |  |  |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   | 29b. Signature and title of certifier<br>Theodore M. King  |  | 29c. License number<br>O.C.M.E.  |   | 29d. Date signed (Month, Day, Year)<br>DECEMBER 26, 1997   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201  |   |  |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>DEC 31 1997   |   | 32. Registrar's Signature<br>Julia Davidson-Randall  |  |  |   |  |  |  |

To Be Completed by Funeral Director

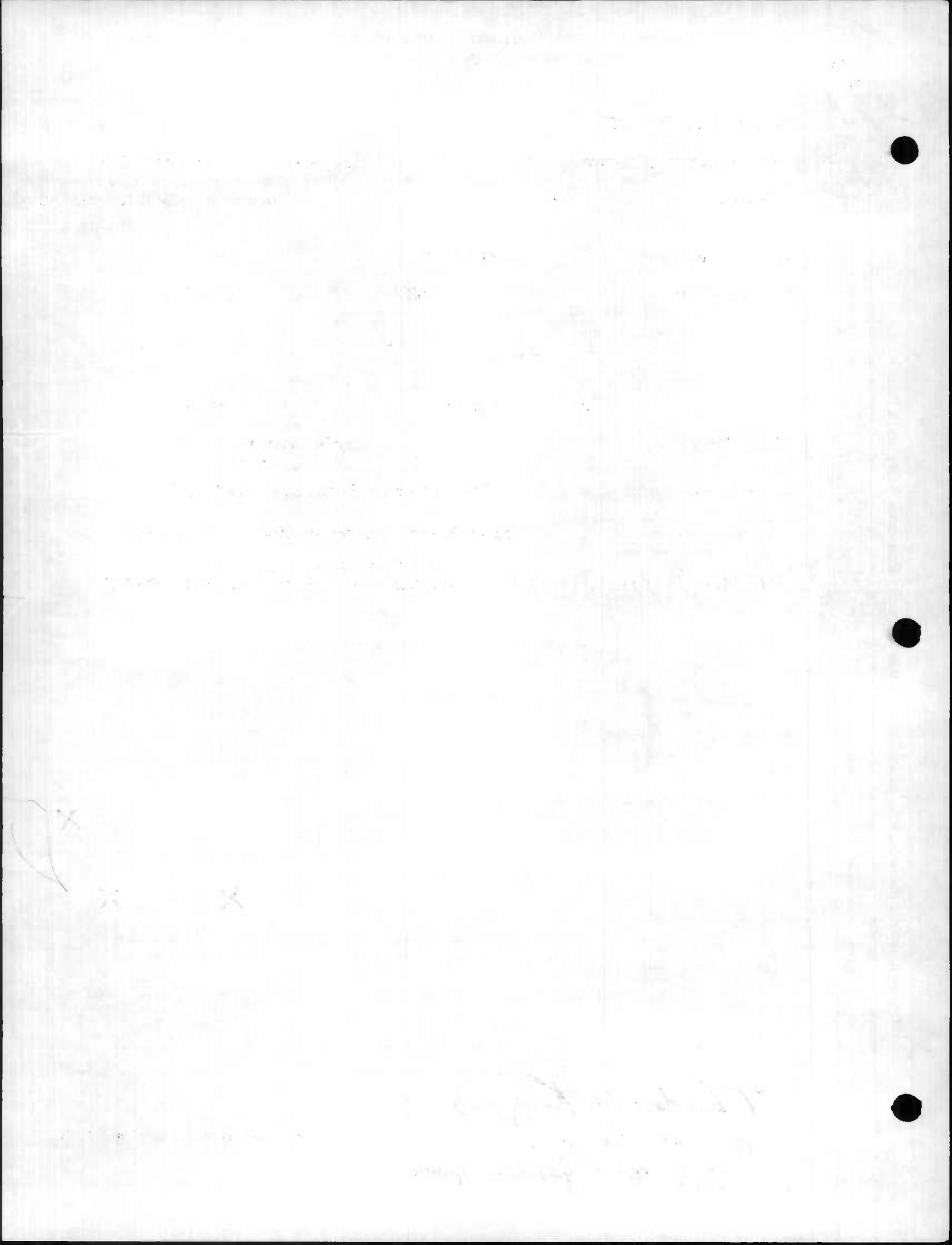
Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39844

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Roy Eugene Shaffer

2. Date of Death  
Month Day Year

December 23, 1997

7:30 A.M.

4a. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

376-22-9867

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

August 7, 1927

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

400 Maple View Dr.

10f. Zip Code

21014

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1945-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 yrs

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nuclear Physicist

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Harry Saul Shaffer

18. Mother's Name (First, Middle, Maiden Surname)

Erma Catherine Duncan

19a. Informant's Name/Relationship (Type, Print)

Mary E. Shaffer wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

400 Maple View Dr. Bel Air, Md. 21014

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount

Date

12-24

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Schimunek Funeral Home of Bel Air, Inc.  
610 MacPhail Rd. Bel Air, Md. 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ADENOCARCINOMA OF LUNG

6 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RESPIRATORY FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

5 ☐ Pending investigation

2 ☐ Accident

6 ☐ Could not be determined

3 ☐ Suicide

4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, a/c. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician

2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]* Edward J. ...

29c. License number

231775

29d. Date signed (Month, Day, Year)

DECEMBER 23, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN P. EDWARDS, MD

212 BELAIR ROAD FALLSTON, MARYLAND 21047

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

*[Signature]* Julia Davidson-Rendell

State  
Registrar

Division of Vital Records, P.O. Box 68760,

Shaffer, Roy Eugene  
Baltimore, Maryland 21215-0020



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39845

|  |   |  |   |  |   |   |  |   |  |  |
|--|---|--|---|--|---|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>NAOMI M. SADOWSKI</b>  |  |   |  | 2. Date of Death<br>Month <b>December</b> Day <b>29</b> , Year <b>1997</b>  |   |  |   | 3. Time of Death<br><b>9:00 P.M.</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Westminister Nursing Home</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Westminister</b>   |   |  |   | 4c. County of Death<br><b>Carroll</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>215-42-9177</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 19, 1909</b>                     |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                    |  |
|  | Usual Residence of Decedent   |  |   |  |   |   |  |   |  |  |
| To Be Completed by Funeral Director                                  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>   |   |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|  | 10e. Street and Number<br><b>3411 Juneway</b>   |  |   |  | 10f. Zip Code<br><b>21213</b>   |   | 10g. Citizen of What Country?<br><b>U. S. A.</b>                                 |   |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:        |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>12th Grade</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary</b>   |  | 16b. Kind of Business/Industry<br><b>Medical Office</b>   |   |  |   |  |  |
| To Be Completed by Physician/Medical Examiner                        | 17. Father's Name (First, Middle, Last)<br><b>Louis Nelson Minnick</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Imhoff</b>   |   |  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>James F. Sadowski (Son)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3411 Juneway, Baltimore, Maryland 21213</b> |   |  |   |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Most Holy Redeemer</b>   |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>   |   | 20d. Date<br><b>1/2/98</b>   |   |  |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Schimunek Funeral Home Inc.</b><br><b>3331 Brehms Lane, Baltimore, Maryland 21213</b>                    |   |  |   |  |  |
| Physician<br>/Medical<br>Examiner                                    | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>advanced lymphatic cancer</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br><b>unk</b> |  |   |  |   |   |  |   |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>dementia</b>   |  |   |  |   |   |  |   |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |   |  |   |   |  |   |  |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |   |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |   |  |   |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>018477</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>12 30 97</b>                           |   |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Marlene S. Peksa 16105 Frederick Rd Lishan MD</b>  |  |   |  |   |   |  |   |  |  |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)<br><b>1-DEC 31 1997</b>   |  |   |  | 32. Registrar's Signature<br><br><b>21765</b>                |   |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39846

|  |   |   |  |   |  |  |  |  |   |  |  |
|--|---|---|--|---|--|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>James C. Sobus</b>                           |   |  |   |  |  | 2. Date of Death<br>Month Day Year<br><b>December 26, 1997</b> |  | 3. Time of Death<br><b>12:20 PM</b>                         |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>4244 E. Joppa Road</b> |   |  |   |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>       |  | 4c. County of Death<br><b>Baltimore</b>                     |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>216-42-2279</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>55</b> Yrs. |  | 8. Date of Birth (Month, Day, Year)<br><b>March 2, 1942</b>    |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |  |  |
|  | Usual Residence of Decedent   |   |  |   |  |  |  |  |   |  |  |
| 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>   |  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |
| 10a. Street and Number<br><b>4244 E. Joppa Road</b>  |   |   |  | 10f. Zip Code<br><b>21236</b>   |  |  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>2</b>   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Park Maintenance Supervisor</b>   |  |  |  | 16b. Kind of Business/Industry<br><b>Municipal Government</b>  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>James M. Sobus</b>   |   |   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Loretta Mannion</b>  |  |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary B. Sobus (wife)</b>  |   |   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4244 E. Joppa Rd., Baltimore, MD 21236</b> |  |  |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. Joseph Church Cem.</b>   |  | 20c. Location - City or Town, State<br><b>12/29/97 Baltimore, Maryland</b>   |  |  |   |  |  |
| 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br><b>Schimunek Funeral Homes, Inc.<br/>9705 Belair Rd., Baltimore, MD 21236</b>   |  |  |  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>e. <b>Adenocarcinoma of Unknown Primary Site</b><br>Due to (or as a consequence of):<br><br>b. _____<br>Due to (or as a consequence of):<br><br>c. _____<br>Due to (or as a consequence of):<br><br>d. _____ |   |   |  |   |  |  |  |  |   | Approximate Interval Between Onset and Death |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |  |
|  |   |   |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |
|  |   |   |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred  |   |  |  |
|  |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner  |   | 29b. Signature and title of certifier<br>  |  |   |  |  |  |  |   |  |  |
|  |   | 29c. License number<br><b>038409</b>  |  |   |  | 29d. Date signed (Month, Day, Year)<br><b>12/29/97</b>   |  |  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>4940 Eastern Ave Baltimore Md 21224</b>   |   |   |  |   |  |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>  |   | 32. Registrar's Signature<br>  |  |   |  |  |  |  |   |  |  |

Baltimore, Maryland 21215-0020

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Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 39847

Amended #26 per MEO G754 12/31/97 EW

## Certificate of Death

Reg. No.

|  |  |                           |   |   |  |  |  |   |   |   |    |                        |                                  |  |    |            |                                  |  |    |            |                                  |  |    |                     |                                  |  |
|--|--|---------------------------|---|---|--|--|--|---|---|---|----|------------------------|----------------------------------|--|----|------------|----------------------------------|--|----|------------|----------------------------------|--|----|---------------------|----------------------------------|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Mildred M. Sanders</b>                    |                           |   |   |  | 2. Date of Death<br>Month <b>December</b> Day <b>16</b> Year <b>1997</b>                   |  | 3. Time of Death<br><b>8:30 PM</b>                                      |   |   |    |                        |                                  |  |    |            |                                  |  |    |            |                                  |  |    |                     |                                  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>2423 Ellis Road</b> |                           |   |   |  | 4b. City, Town, or Location of Death<br><b>N/A</b>   |  | 4c. County of Death<br><b>Baltimore</b>                                 |   |   |    |                        |                                  |  |    |            |                                  |  |    |            |                                  |  |    |                     |                                  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-36-2448</b>  |                           | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>08/27/1910</b>                                       |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |   |    |                        |                                  |  |    |            |                                  |  |    |            |                                  |  |    |                     |                                  |  |
|  | Usual Residence of Decedent  |                           |   |   |  |  |  |   |   |   |    |                        |                                  |  |    |            |                                  |  |    |            |                                  |  |    |                     |                                  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>N/A</b> |   | 10c. City, Town or Location<br><b>Baltimore</b>   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |   |   |    |                        |                                  |  |    |            |                                  |  |    |            |                                  |  |    |                     |                                  |  |
| 10e. Street and Number<br><b>404 S. Robinson Street</b>  |  |                           |   |   | 10f. Zip Code<br><b>21224</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |   |   |    |                        |                                  |  |    |            |                                  |  |    |            |                                  |  |    |                     |                                  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |   |   |    |                        |                                  |  |    |            |                                  |  |    |            |                                  |  |    |                     |                                  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11th</b> College (1-4 or 5+)   |  |                           |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Teacher</b> |  |  | 16b. Kind of Business/Industry<br><b>Education</b>   |   |   |   |    |                        |                                  |  |    |            |                                  |  |    |            |                                  |  |    |                     |                                  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Henry Granville</b>  |  |                           |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary E. Knoble</b>   |  |  |   |   |   |    |                        |                                  |  |    |            |                                  |  |    |            |                                  |  |    |                     |                                  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>H. Beverly Woodruff/Daughter</b>  |  |                           |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1537 Rosewick Ave. Baltimore, Maryland 21237</b>   |  |  |   |   |   |    |                        |                                  |  |    |            |                                  |  |    |            |                                  |  |    |                     |                                  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Oak Lawn Cemetery</b>  |   |  | Date<br><b>12/20/97</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>       |   |   |    |                        |                                  |  |    |            |                                  |  |    |            |                                  |  |    |                     |                                  |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  |                           |   |   | 22. Name and Address of Facility<br><b>Hoffman-Skarda Funeral Home</b><br><b>3218 Hudston Street Baltimore, Maryland 21224</b>   |  |  |   |   |   |    |                        |                                  |  |    |            |                                  |  |    |            |                                  |  |    |                     |                                  |  |
| 23e. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>aortic stenosis</b></td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>b.</td> <td><b>CAD</b></td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c.</td> <td><b>HTN</b></td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td><b>dyslipidemia</b></td> <td>Due to (or as a consequence of):</td> <td></td> </tr> </table> |  |                           |   |   |  |  |  |   |   | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | <b>aortic stenosis</b> | Due to (or as a consequence of): |  | b. | <b>CAD</b> | Due to (or as a consequence of): |  | c. | <b>HTN</b> | Due to (or as a consequence of): |  | d. | <b>dyslipidemia</b> | Due to (or as a consequence of): |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | a.   | <b>aortic stenosis</b>    | Due to (or as a consequence of):  |   |  |  |  |   |   |   |    |                        |                                  |  |    |            |                                  |  |    |            |                                  |  |    |                     |                                  |  |
|  | b.   | <b>CAD</b>                | Due to (or as a consequence of):  |   |  |  |  |   |   |   |    |                        |                                  |  |    |            |                                  |  |    |            |                                  |  |    |                     |                                  |  |
|  | c.   | <b>HTN</b>                | Due to (or as a consequence of):  |   |  |  |  |   |   |   |    |                        |                                  |  |    |            |                                  |  |    |            |                                  |  |    |                     |                                  |  |
|  | d.   | <b>dyslipidemia</b>       | Due to (or as a consequence of):  |   |  |  |  |   |   |   |    |                        |                                  |  |    |            |                                  |  |    |            |                                  |  |    |                     |                                  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>dysrhythmia</b>   |  |                           |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |   |   |   |    |                        |                                  |  |    |            |                                  |  |    |            |                                  |  |    |                     |                                  |  |
|  |  |                           |   |   | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |   |   |    |                        |                                  |  |    |            |                                  |  |    |            |                                  |  |    |                     |                                  |  |
|  |  |                           |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>N/A</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                 |  |  |   |   |   |    |                        |                                  |  |    |            |                                  |  |    |            |                                  |  |    |                     |                                  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                           | 28. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>Care Givers Home</b> |   |  |  |  |   |   |   |    |                        |                                  |  |    |            |                                  |  |    |            |                                  |  |    |                     |                                  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  |                           | 28e. Date of Injury (Month, Day, Year)<br><b>N/A</b>  |   | 28b. Time of Injury<br><b>N/A</b> M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   | 28d. Describe how Injury occurred<br><b>N/A</b>             |   |    |                        |                                  |  |    |            |                                  |  |    |            |                                  |  |    |                     |                                  |  |
|  |  |                           | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>N/A</b>  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>N/A</b> |  |   |   |   |    |                        |                                  |  |    |            |                                  |  |    |            |                                  |  |    |                     |                                  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |                           | 29b. Signature and title of certifier<br><i>[Signature]</i>   |   |  | 29c. License number<br><b>D35304</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>12/18/97</b>                  |   |   |    |                        |                                  |  |    |            |                                  |  |    |            |                                  |  |    |                     |                                  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type-Print)<br><b>Dr. ENOCH 3411 Bank St., Baltimore, MD, 21224</b>  |  |                           |   |   |  |  |  |   |   |   |    |                        |                                  |  |    |            |                                  |  |    |            |                                  |  |    |                     |                                  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>  |  |                           | 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |  |  |   |   |   |    |                        |                                  |  |    |            |                                  |  |    |            |                                  |  |    |                     |                                  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39848

|   |  |  |   |  |  |  |   |   |  |  |
|---|--|--|---|--|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>SELMA STANLEY</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>DECEMBER 28, 1997</b>   |  |   |   | 3. Time of Death<br><b>11 A.M.</b>   |  |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>1701 EUTAW PLACE (HOME)</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  |   |   | 4c. County of Death<br><b>N/A</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>246-20-0197</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>70</b> Yrs.   |  | 8. Date of Birth<br>Month Day Year<br><b>JUNE 29, 1927</b>                                  |   | 9. Birthplace (State or Foreign Country)<br><b>WILMINGTON, N.C.</b>                            |  |
|   | Usual Residence of Decedent  |  |   |  |  |  |   |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MARYLAND</b>  |  | 10b. County<br><b>BALTIMORE</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|   | 10e. Street and Number<br><b>1701 EUTAW PLACE, APT 727</b>   |  |   |  | 10f. Zip Code<br><b>21217</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |   |  |  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>45 - 47</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>AFRO.AMERICAN</b> |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>TRUCK DRIVER</b>   |  |   |   | 16b. Kind of Business/Industry<br><b>TRUCK COMPANY</b>   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>JOHN E. STANLEY</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>LILLIE GORE STANLEY</b>  |  |   |   |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>MARIE SMITHSON SISTER</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1701 EUTAW PLACE, BALTIMORE, MARYLAND 21217</b>  |  |   |   |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GARRISON FOREST CEMETERY</b>  |  | 20c. Location - City or Town, State<br><b>1/2/98 OWINGS MILLS, MD.</b>                      |   |  |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>ESTEP BROTHERS FUNERAL HOME, P.A.<br/>1300 EUTAW PLACE, BALTIMORE, MARYLAND 21217</b>   |  |   |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |  |   |   |  |  |
|   | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |   |   |  |  |
| Physician<br>/Medical<br>Examiner   | Immediate Cause (Final disease or condition resulting in death)<br>a. <b>NATURAL CAUSES</b><br>Due to (or as a consequence of):<br>b. <b>CARDIOVASCULAR DISEASE</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |   |   |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |  |  |   |   |  |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |   |  |  |
|   | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |   |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury et Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |  |  |  |   |   |  |  |
| 29b. Signature and title of certifier<br>  |  |  |   |  | 29c. License number<br><b>D47635</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>December 29, 1997</b>                             |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DEAN E. JOHNSON 10 N Greene St, BALTIMORE, MD</b>  |  |  |   |  |  |  |   |   |  |  |
| State<br>Registrar  | 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>  |  |   |  | 32. Registrar's Signature<br>   |  |   |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39849

|  |   |   |  |                               |   |  |  |   |
|--|---|---|--|-------------------------------|---|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>ALFRED E. SCOTT   |   |  |                               | 2. Date of Death<br>Month Day Year<br>12/23/97  |  | 3. Time of Death<br>11:25 AM   |   |
|  | 4a. Facility Name (If not institution, give street and number)<br>GAMBRO HEALTH CARE MERCY  |   |  |                               | 4b. City, Town, or Location of Death<br>BALTIMORE   |  | 4c. County of Death<br>N/A   |   |
| Funeral<br>Director  | 5. Social Security Number<br>219 22 9676  |   | 6. Sex<br>1# M 2# F  |                               | 7. Age (In yrs. last birthday)<br>67 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>6/29/30                           |   |
|  | 10a. State<br>MD.   |   | 10b. County<br>N/A   |                               | 10c. City, Town or Location<br>BALTIMORE  |  | 10d. Inside City Limits<br>1# Yes 2# No                                  |   |
| To Be Completed by Funeral Director  | 10e. Street and Number<br>431 S, GILMOR ST.   |   |  |                               | 10f. Zip Code<br>21223  |  | 10g. Citizen of What Country?<br>USA                                     |   |
|  | 11. Marital Status<br>1# Never Married 2# Married 3# Widowed 4# Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1# Yes 2# No 11/50  |                               | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1# Yes 2# No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: AFR. AMERICAN |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11 College (1-4or 5+) 0  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>LABORER |                               | 16b. Kind of Business/Industry<br>BETHLEHEM STEEL   |  |  |   |
|  | 17. Father's Name (First, Middle, Last)<br>SPENCER SCOTT  |   |  |                               | 18. Mother's Name (First, Middle, Maiden Surname)<br>HELEN MYERS  |  |  |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>ARMINTA SCOTT WIFE  |   |  |                               | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>431 S. GILMOR ST. BALTO. MD. 21223   |  |  |   |
|  | 20a. Method of Disposition<br>1# Burial 2# Cremation 3# Removal from State 4# Donation 5# Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>METRO CREMATORY                            |                               | Date<br>12/26/97  |  | 20c. Location - City or Town, State<br>CATONSVILLE, MD.                  |   |
|  | 21. Signature of Funeral Service Licensee<br><i>Carl A. Estep</i>   |   |  |                               | 22. Name and Address of Facility<br>ESTEP BROTHERS FUNERAL HOME P.A.<br>1300 EUTAW PL. BALTO. MD. 21217                               |  |  |   |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. CARDIAC Arrhythmia<br>Due to (or as a consequence of):<br>b. CORONARY Artery Disease<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |  |                               |   |  |  | Approximate Interval Between Onset and Death<br>1 minute<br>10 years                          |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>END STAGE Renal Disease<br>DILATED CARDIOMYOPATHY<br>Chronic OBSTRUCTIVE Pulmonary Disease  |   |  |                               |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1# Yes 2# No 3# Probably 4# Unknown |
|  | 25. Was case referred to medical examiner?<br>1# Yes 2# No  |   | Hospital: 1# Inpatient 2# ER/Outpatient 3# DOA   |                               | 28. Place of Death (Check only one)<br>Other: 4# Nursing Home 5# Residence 6# Other (Specify) <i>Prison Facility</i>                  |  | 23c. Was an autopsy performed?<br>1# Yes 2# No                           |   |
| 27. Manner of Death<br>1# Natural 2# Accident 3# Suicide 4# Homicide 5# Pending Investigation 6# Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)                              |  | 28b. Time of Injury<br>M      |   | 28c. Injury at Work?<br>1# Yes 2# No               |  |   |
| 29a. Certifier (Check only one)<br>1# Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2# Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><i>Robert C. Greenwell</i> |  | 29c. License number<br>D34334 |   | 29d. Date signed (Month, Day, Year)<br>Dec 23 1997 |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>ROBERT C. Greenwell Sr MD 315 N. CALVERT ST. Baltimore MD 21202  |   |   |  |                               |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br>DEC 31 1997   |   | 32. Registrar's Signature<br><i>Julia Davidson-Rendall</i>          |  |                               |   |  |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

State Registrar

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page. The text is mostly centered and spans most of the page area.]*

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39850

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Michael John Speranzella, Sr.

2. Date of Death

Month December Day 29 Year 97

3. Time of Death

1:00 PM

4a. Facility Name (If not institution, give street and number)

9645 White Acre Road Unit A-1

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

219-03-1551

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

May 30, 1919

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

9645 White Acre Road

10f. Zip Code

21045

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Metallurgist

16b. Kind of Business/Industry

Bethlehem Steel

17. Father's Name (First, Middle, Last)

Guiseppe Speranzella

18. Mother's Name (First, Middle, Maiden Surname)

Maria Terzano

19a. Informant's Name/Relationship (Type, Print)

Verona Speranzella (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9645 White Acre Road, Columbia, MD 21045

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Mem. Park

Date

Jan. 2, 1998

20c. Location - City or Town, State

Dorsey, MD

21. Signature of Funeral Service Licensee

Robert S. Bueh

22. Name and Address of Facility

Witzke Funeral Homes, Inc.  
5555 Twin Knolls Rd. Columbia, MD 21045

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac arrest

Due to (or as a consequence of):

Approximate interval Between Onset and Death

minutes

b. Lymphoma

Due to (or as a consequence of):

four years

c. Coronary Artery disease

Due to (or as a consequence of):

years

d. Renal insufficiency

Due to (or as a consequence of):

years

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of causa of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

28. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Schwartz

29c. License number

D50776

29d. Date signed (Month, Day, Year)

12/30/97

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Steven A. Everstey MD 4501 Dorsey Hall Drive Suite 201 B Ellicott City MD

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

Julia Davidson-Rondelle

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit.

5+1



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

39851

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Deborah Ann St. John

2. Date of Death  
Month Day Year  
Dec. 27 1997

3. Time of Death  
6:30 PM

4a. Facility Name (If not institution, give street and number)

309 Greenlow Road

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number  
219-60-3369

8. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)  
43 Yrs.

If Under 1 Year  
Months Days

If Under 24 Hrs.  
Hours Min.

8. Date of Birth  
(Month, Day, Year)  
MAR. 29, 1954

9. Birthplace (State or Foreign Country)  
MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

CATONSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

309 GREENLOW ROAD

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

ADMINISTRATIVE OFFICER

16b. Kind of Business/Industry

DEPARTMENT OF COMMERCE

17. Father's Name (First, Middle, Last)

WILLIAM ROBINSON

18. Mother's Name (First, Middle, Maiden Surname)

MILDRED L. SHIFLETT

19a. Informant's Name/Relationship (Type, Print)

RICHARD G. ST. JOHN, HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

309 GREENLOW ROAD, CATONSVILLE, MARYLAND 21228

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)  
BALTIMORE/WASHINGTON CREMATORY

Date

12/31/97

20c. Location - City or Town, State

LAUREL, MARYLAND

21. Signature of Funeral Service Licensee

*Robert Guyer*

22. Name and Address of Facility

WITZKE FUNERAL HOMES, INC.  
1630 EDMONDSON AVENUE, CATONSVILLE, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MALIGNANT MESOTHELIOMA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 YEAR

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

HODGKINS DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury  
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)

2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*Scott Maurer MD*

29c. License number

D29909

29d. Date signed (Month, Day, Year)

DEC. 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SCOTT MAURER MD 9501 OLD ANNAPOLIS RD ELLICOTT CITY MD 21042

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

*Julia Davidson-Randall*

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

37 39852

|   |   |  |  |  |   |  |   |  |
|---|---|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Marion Louise Sunderland</b>   |  |  |  | 2. Date of Death<br>Month <b>December</b> Day <b>28</b> , Year <b>1997</b>  |  | 3. Time of Death<br><b>1446</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Anne Arundel Medical Center</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Annapolis</b>  |  | 4c. County of Death<br><b>Anne Arundel</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>219-07-2599</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 28, 1916</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Annapolis</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  | 10e. Street and Number<br><b>2021 Harbor Gates Drive Apt. 238</b>   |  | 10f. Zip Code<br><b>21401</b>   |  |
|   | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |  | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>           |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Auditor</b>   |  |  |  | 16b. Kind of Business/Industry<br><b>State of Maryland</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>Henry Byron Sunderland</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Stella Cole</b>   |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>David Sunderland-Nephew</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1943 Severn Grove Road, Annapolis, MD 21401</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>All Hallows Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>Davidsonville, MD</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Thomas Q. Hardesty Jr.</b>  |  |  |  | 22. Name and Address of Facility<br><b>Hardesty Funeral Home, P.A.<br/>12 Ridgely Ave. Annapolis, MD 21401</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Arteriosclerotic cardiovascular disease</b><br>Due to (or as a consequence of):<br><b>b. Hypertension</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |  |  | Approximate Interval Between Onset and Death  |  |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Esophageal hiatal hernia<br/>cholelithiasis, cholecystitis</b>   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |  |
|   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  | 28d. Describe how injury occurred   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |  | 29b. Signature and title of certifier<br><b>Dr. G. Mitchell</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29c. License number<br><b>014758</b>  |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>12-27-97</b>  |  |   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>621 Bursell Ave Annapolis MD 21401</b>   |  |  |  | 31. Data filed (Month, Day, Year)<br><b>DEC 31 1997</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>  |  |  |  | 33. Registrar's Title<br><b>Registrar</b>   |  |   |  |
|   | 34. Registrar's Address<br><b>621 Bursell Ave Annapolis MD 21401</b>  |  |  |  | 35. Registrar's Phone<br><b>410-221-1111</b>  |  |   |  |

5

Edward J. J. J.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97-39853

|   |   |   |  |  |   |   |   |   |   |  |  |
|---|---|---|--|--|---|---|---|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>IDA L. SHESTACK</b>                      |   |  |  | 2. Date of Death<br>Month <b>DEC</b> Day <b>27</b> Year <b>97</b> |   | 3. Time of Death<br><b>2042</b>                             |   |   |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Sinai Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>          |   | 4c. County of Death<br><b>CITY</b> N/A                      |   |   |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>202-01-1903</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>93</b> Yrs.                  |   | 8. Date of Birth (Month, Day, Year)<br><b>SEPT. 6, 1904</b> |   |   |  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>RUSSIA</b>                               |   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>N/A</b>   |   | 10c. City, Town or Location<br><b>BALTIMORE</b>             |   |   |  |  |
| Usual Residence of Decedent   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>6314 WIRT AVENUE</b>  |   | 10f. Zip Code<br><b>21215</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |   |  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                               |   |   |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>OFFICE MANAGER</b>                |  | 16b. Kind of Business/Industry<br><b>ZIONIST ORGANIZATION</b>  |   |   |   |   |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>MOSHE SHESTACK</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ESTHER RACZKOWSKI</b>  |   |   |   |   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>RABBI JOEL FELDMAN / NEPHEW</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6314 WIRT AVENUE BALTIMORE, MD 21215</b>   |   |   |   |   |   |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MT. SHARON</b>  |   | Date<br><b>12/28/97</b>   |   | 20c. Location - City or Town, State<br><b>SPRINGFIELD, PA</b>                               |   |  |  |
| 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br><b>Sol Levinson &amp; Bros., Inc.<br/>8900 Reisterstown Road Pikesville, MD 21208</b>  |   |   |   |   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>pneumonia - probable Aspiration</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Malignancy - unspecified</b><br><b>Dementia</b><br>Due to (or as a consequence of):<br><br>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Congestive Heart failure</b><br><b>Malignancy - unspecified</b><br><b>Dementia</b> |   |   |  |  |   |   |   | Approximate Interval Between Onset and Death<br><b>3 days</b>                               |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |   |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |   |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |   |   |  | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how Injury occurred                        |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |   |  | 29b. Signature and title of certifier<br>   |   |   |   | 29c. License number<br><b>030377</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>Dec 27, 97</b> |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Robert M. Cooper MD 98 N. Broadway BALTIMORE Maryland 21231</b>  |   |   |  |  |   |   |   |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>   |   |   |  | 32. Registrar's Signature<br>   |   |   |   |   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39854

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

FANNIE SIMMONS

2. Date of Death

Month Day Year  
Dec 27, 1997

3. Time of Death

100 AM

Funeral  
Director

4a. Facility Name (If not Institution, give street and number)

NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

5. Social Security Number

214-20-0005

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
SEPT. 01, 1905

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2 HIGH STEPPER COURT, APT. 502

10f. Zip Code

21208

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Navar Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

LOUIS CHAID

18. Mother's Name (First, Middle, Maiden Surname)

IDA SNYDER

19a. Informant's Name/Relationship (Type, Print)

ROSLYN BLANKMAN/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2 HIGH STEPPER CT; #502; BALTIMORE, MD 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

PETACH TIKVAH

Date

12-28-1997 BALTIMORE, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Seth M. Little

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.  
8900 REISTERSTOWN RD; PIKESVILLE, MD 2120823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Respiratory Failure  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

Unknown

b. Diabetes  
Due to (or as a consequence of):

Unknown

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter underlying  
cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician2 ☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Anthony J. Gordon

29c. License number

50454

29d. Date signed (Month, Day, Year)

Dec 27, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Y A ZAKI, A RASTOO NORTHWEST HOSPITAL CENTER

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

Julia Davidson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
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within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

602

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39855

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GLADYS ESTELLE SHANAHAN

2. Date of Death

Month Day Year  
DECEMBER 25, 1997

3. Time of Death

10:00A.M.

4a. Facility Name (If not institution, give street and number)

1258 GREYSTONE ROAD

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

217-03-9531

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
APRIL 15, 1903

9. Birthplace (State or Foreign Country)

BALTIMORE

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1258 GREYSTONE ROAD

10f. Zip Code

21227

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8TH GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

GEORGE W. TURNER

18. Mother's Name (First, Middle, Maiden Surname)

CAROLINE HOFFER

19a. Informant's Name/Relationship (Type, Print)

SHIRLEY C. SHANAHAN (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1258 GREYSTONE ROAD - ARBUTUS, MD. 21227

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

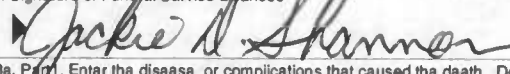
cemetery, crematory or other place)

NEW CATHEDRAL CEMETERY 12/27/97 BALTIMORE

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

HUBBARD FUNERAL HOME INC.  
4107 WILKENS AVENUE-BALTIMORE, MD 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Severe chronic obstructive Pulmonary Disease years

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Congestive Heart Failure

Due to (or as a consequence of):

c. Coronary artery Disease

Due to (or as a consequence of):

d. Hypertension

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Gastritis

Aneurysm

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy

performed?

1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

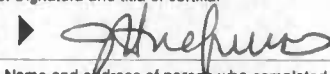
Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)
☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D47595

29d. Date signed (Month, Day, Year)

Dec. 26, 1997

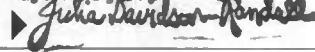
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Julianne Huefner MD 1518 Sulphur Spring Road, Arbutus MD 21227

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature


State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39856

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Wilmer J Shilow, JR.

2. Date of Death

Month Day Year  
December 24, 1997 11:34am

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

UNIVERSITY HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

214-30-4484

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
OCT 15, 1935

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

ANNE ARUNDEL

10c. City, Town or Location

LINTHICUM

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1217 FURNACE ROAD

10f. Zip Code

21090

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12TH GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

SHEET METAL MECHANIC

16b. Kind of Business/Industry

BALTO CITY HOUSING

17. Father's Name (First, Middle, Last)

WILMER J. SHILOW, SR.

18. Mother's Name (First, Middle, Maiden Surname)

ELLA BELL

19a. Informant's Name/Relationship (Type, Print)

LINDA SHILOW (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1217 FURNACE ROAD - LINTHICUM, MD 21090

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

LOUDON PARK CEMETERY

Date

12/27/97

20c. Location - City or Town, State

BALTIMORE

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HUBBARD FUNERAL HOME INC.

4107 WILKENS AVENUE-BALTIMORE, MD

21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hepatic Encephalopathy  
Due to (or as a consequence of):

6 days

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Metastatic Lung Cancer  
Due to (or as a consequence of):

19 days

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pancreatitis

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

26. Place of Death (Check only one)

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

AU4176435

29d. Date signed (Month, Day, Year)

December 24, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Riba C. Kelsey, M.D. 22 South Green Street Baltimore Maryland 21201

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

3

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39857

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Walter William Sippel

2. Date of Death

Month December 29, 1997 Year

3. Time of Death

2:45 a.m.

4e. Facility Name (If not institution, give street and number)

120 Sippel Avenue

4b. City, Town, or Location of Death

Baltimore County

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

216-12-8139

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

90

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

September 18, 1907

9. Birthplace (State or Foreign Country)

Baltimore, Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore County

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

120 Sippel Avenue

10f. Zip Code

21236

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6

N/A

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Plasterer

16b. Kind of Business/Industry

William Hammen

17. Father's Name (First, Middle, Last)

Louis Sippel

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude Marx

19a. Informant's Name/Relationship (Type, Print)

Laverne M. Foard (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

120 Sippel Avenue Baltimore, Maryland 21236

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Oak Lawn Cemetery December 31, 1997

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Walter William Sippel

22. Name and Address of Facility

Lassahn Funeral Home, Inc.

7401 Belair Road Baltimore, Maryland 21236-4625

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Intracerebral hemorrhage

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. Crossan Donovan, M.D.

29c. License number

207632

29d. Date signed (Month, Day, Year)

DEC 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Crossan Donovan, M.D., 242 DUNDALK AVE

BALTO MD 21222

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Medical Examiner's Signature

J. Crossan Donovan

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39858

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Donald Albert Schmidt, Sr.

2. Date of Death

Month Day Year  
December 29 1997

3. Time of Death

2:54 P.M.

4a. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

217-36-2525

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

57

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 5, 1940

9. Birthplace (State or Foreign Country)

Baltimore Co., Md.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Kingsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12127 Stoney Batter Road

10f. Zip Code

21087

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
9yrs.College (1-4or 5+)  
n/a16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Body and Fender Man

16b. Kind of Business/Industry

Fork Paint and Repair

17. Father's Name (First, Middle, Last)

Emil Ferdinand Schmidt

18. Mother's Name (First, Middle, Maiden Surname)

Eileen Anna Snyder

19a. Informant's Name/Relationship (Type, Print)

Mrs. Arlene J. Schmidt (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12127 Stoney Batter Road Kingsville, Md. 21087

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

BelAir Memorial Gardens

Date

12/31/97

20c. Location - City or Town, State

BelAir, Maryland 21014

21. Signature of Funeral Service Licensee

E. F. Lassahn

22. Name and Address of Facility

E. F. Lassahn Funeral Home

11750 Belair Road Kingsville, Md. 21087

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

Acute Pulmonary Edema due to hours  
Due to (or as a consequence of) Acute myocardial infarction

b.

Coronary Artery disease (with history years  
Due to (or as a consequence of):

c.

of Angina and myocardial infarction  
Due to (or as a consequence of):

d.

and prior congestive heart failure and

Approximate  
Interval Between  
Onset and DeathSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury)  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Ventricular Tachycardia  
Non-insulin dependent diabetes  
mellitus, hypertension, obesity, emphysema

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)
☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Albert S. C. Sun, M.D.

29c. License number

MD-D 18779

29d. Date signed (Month, Day, Year)

December 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1800 HARFORD ROAD, FALLSTON, MD 21047

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39859

|   |  |   |  |  |  |   |  |  |
|---|--|---|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><i>ELLA Schueler</i>   |   |  |  | 2. Date of Death<br>Month <i>12</i> Day <i>29</i> Year <i>97</i> |   | 3. Time of Death<br><i>12:01 AM</i>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><i>University of Maryland Hospital</i> |   |  |  | 4b. City, Town, or Location of Death<br><i>Baltimore</i>         |   | 4c. County of Death<br><i>Baltimore City</i>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><i>218-32-8870</i>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><i>61</i> Yrs.                 |   | 8. Date of Birth (Month, Day, Year)<br><i>Aug. 5, 1936</i>                                     |  |
|   | 9. Birthplace (State or Foreign Country)<br><i>Freeland, Md.</i>   |   |  |  |  |   |  |  |
| Usual Residence of Decedent   |  |   |  |  |  |   |  |  |
| 10a. State<br><i>Maryland</i>   |  | 10b. County<br><i>Baltimore</i>   |  | 10c. City, Town or Location<br><i>White Marsh</i>  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><i>5903 Loreley Beach Road</i>  |  |   |  | 10f. Zip Code<br><i>21162</i>  |  | 10g. Citizen of What Country?<br><i>U.S.A.</i>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12th.</i><br>College (1-4 or 5+) <i>n/a</i>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Fiscal Clerk</i>   |  |   | 16b. Kind of Business/Industry<br><i>State of Maryland</i>                                     |  |
| 17. Father's Name (First, Middle, Last)<br><i>Herman Daniel Bollinger</i>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Olivia Pearl Curnoles</i>  |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>Mrs. Karen McClelland (Daughter)</i>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>942 Kinwat Avenue Baltimore, Md. 21221</i>   |  |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Gardens of Faith Cemetery</i>  |  | Data<br><i>1/2/98</i>  |  | 20c. Location - City or Town, State<br><i>Baltimore, Md.</i>                                |  |  |
| 21. Signature of Funeral Service Licensee<br><i>E. F. Lassahn</i>   |  |   |  | 22. Name and Address of Facility<br><i>E. F. Lassahn Funeral Home<br/>11750 Belair Road Kingsville, Md. 21087</i>  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Acute Myeloblastic leukemia</i><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |   |  | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|   |  |   |  |  |  |   |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |
|   |  |   |  |  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><i>M</i>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |   |  |  |
| 29b. Signature and title of certifier<br><i>Kennita R Carter MD</i>   |  |   |  | 29c. License number<br><i>P09728</i>   |  | 29d. Date signed (Month, Day, Year)<br><i>12/29/97</i>                                      |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Kennita R Carter, MD 23 South Greene St. Baltimore MD 21201</i>  |  |   |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><i>DEC 31 1997</i>   |  |   |  | Registrar's Signature<br><i>Davidson-Randall</i>   |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39860

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CARROLL A. TENLEY, JR.

2. Date of Death

Month Day Year  
December 27, 1997

3. Time of Death

6:28 A

4e. Facility Name (If not institution, give street and number)

The Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

215-24-8206 A

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
OCT 24 1929

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10e. State

MD

10b. County

HOWARD

10c. City, Town or Location

ELLICOTT CITY

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3733 TAKOYA DRIVE

10f. Zip Code

21042

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No 10-48

If Yes, Give Year or Dates: 10-17-49

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16e. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

CABLE MANUFACTURER

16b. Kind of Business/Industry

WESTERN ELECTRIC

17. Father's Name (First, Middle, Last)

CARROLL A. TENLEY, SR.

18. Mother's Name (First, Middle, Maiden Surname)

HELEN B. BROUGHTON

19a. Informant's Name/Relationship (Type, Print)

EVELYN Q. TENLEY, WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3733 TAKOYA DR., ELLICOTT CITY, MD 21042

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

CRESTLAWN MEMORIAL

Date

12-31

20c. Location - City or Town, State

MARRIOTTSTVILLE, MD

21. Signature of Funeral Service Licensee

Phyllis Stash

22. Name and Address of Facility

STERLING ASHTON FUNERAL HOME, INC.

736 EDMONDSON AVE., BALTIMORE, MD 21228

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

e. ASPERGILLOSIS

2 wks

Due to (or as a consequence of):

b. MYELODYSPLASTIC SYNDROME

15 mos.

Due to (or as a consequence of):

c. SUBCUTANEOUS ABSCESS

2 wks

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28e. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier  
(Check only  
one)
☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Phyllis Stash MD PhD

29c. License number

D46104

29d. Date signed (Month, Day, Year)

12/27/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ROBERT ORLOWSKI, 600 N. WOLF ST, BALTIMORE, MD 21287

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

John Davidson

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
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To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39861

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary A. Turek

2. Date of Death

Month Day Year  
December 23, 1997

3. Time of Death

3:50 AM

4a. Facility Name (If not institution, give street and number)

Manor Care Nursing Center - Towson

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

212-40-6627

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 23, 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4909 Ridge Road

10f. Zip Code

21237

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Peter Zika

18. Mother's Name (First, Middle, Maiden Surname)

Marie Troch

19a. Informant's Name/Relationship (Type, Print)

Charles W. Turek (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4907 Ridge Road, Baltimore, MD 21237

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Most Holy Redeemer Cem.

Date

12/27/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Schimunek Funeral Homes, Inc.  
9705 Belair Rd., Baltimore, MD 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CEREBRAL INFARCTION

Due to (or as a consequence of):

b. ATRIAL FIBRILLATION

Due to (or as a consequence of):

c. ARTERIO SCLEROTIC CARDIOVASCULAR

Due to (or as a consequence of):

d. DISEASE WITH HYPERTENSION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*FAUSTO Q. ARJUNO JR., MD*

29c. License number

014697

29d. Date signed (Month, Day, Year)

12-23-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FAUSTO Q. ARJUNO JR., MD 8713 HARRARD RD., BALTO., MD. 21234

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

*John Davidson-Randall*

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

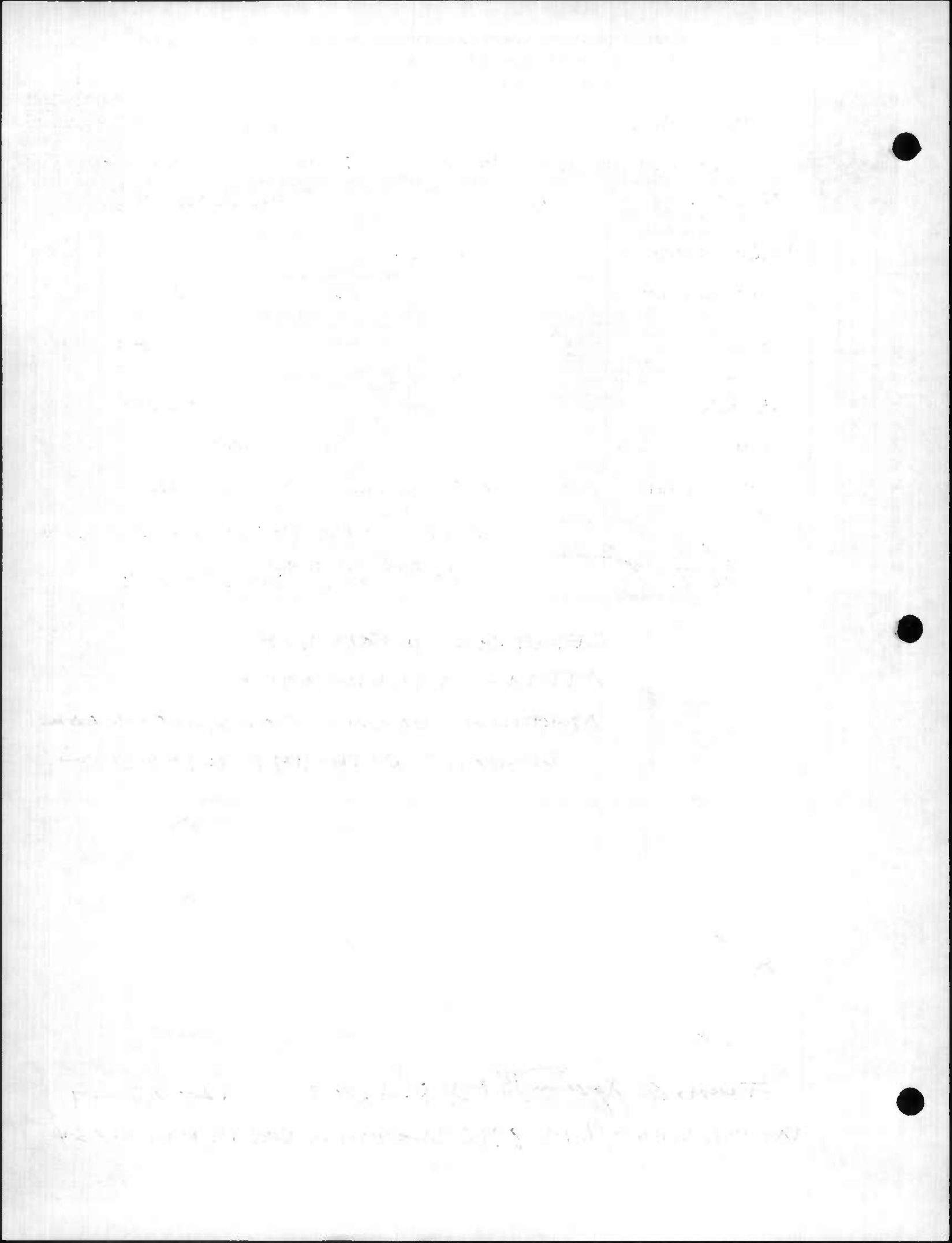
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39862

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Madeline Mary Tull

2. Date of Death

Month Day Year  
DEC. 30, 1997

3. Time of Death

7:56am

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

220-24-7365

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
MAY 20, 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8334 Ritchie Hgwy

10f. Zip Code

21122

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William Harry Stout

18. Mother's Name (First, Middle, Maiden Surname)

Annabelle Eller

19a. Informant's Name/Relationship (Type, Print)

Frances Ann Reed/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8334 Ritchie Hgwy Pasadena, MD 21122

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc.

Date

12/31/97

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Dawn F. McDonald

22. Name and Address of Facility

Cremation Society of Maryland, Inc.  
299 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Coronary artery disease

5-7 yrs

Due to (or as a consequence of):

b. Coronary artery Bypass Graft

5-7 yrs

Due to (or as a consequence of):

c. Chronic obstructive Pulmonary disease

5-7 yrs

Due to (or as a consequence of):

d. Gastritis

1 yr.

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Don. Isaac

29c. License number

40519

29d. Date signed (Month, Day, Year)

12/30/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MUSABIR MOHAMMED 795 BAYVIEW RD GAITHERSBURG MD

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39863

|   |   |   |  |   |  |  |  |  |   |   |   |  |  |  |  |
|---|---|---|--|---|--|--|--|--|---|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><i>Gwyneth W. Trifillis</i>                             |   |  |   | 2. Date of Death<br>Month <i>December</i> Day <i>25</i> Year <i>1997</i> |  | 3. Time of Death<br><i>19:30</i>   |  |   |   |   |  |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><i>The Johns Hopkins Hospital</i> |   |  |   | 4b. City, Town, or Location of Death<br><i>Baltimore</i>                 |  | 4c. County of Death<br><i>N/A</i>  |  |   |   |   |  |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><i>222-18-9171</i>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><i>76</i> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><i>APR. 1, 1921</i>                                  | 9. Birthplace (State or Foreign Country)<br><i>England</i> |   |   |   |  |  |  |  |
|   | Usual Residence of Decedent   |   |  |   |  |  |  |  |   |   |   |  |  |  |  |
| 10a. State<br><i>Maryland</i>   |   | 10b. County<br><i>N/A</i>   |  | 10c. City, Town or Location<br><i>Baltimore</i>   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |   |   |   |  |  |  |  |
| 10e. Street and Number<br><i>3456 Seneca Street</i>   |   |   |  | 10f. Zip Code<br><i>21211</i>   |  | 10g. Citizen of What Country?<br><i>USA</i>                                      |  |  |   |   |   |  |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i>          |  |  |   |   |   |  |  |  |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+)   |   |   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><i>Telephone Operator</i>   |  | 16b. Kind of Business/Industry<br><i>Pepsi Cola</i>                              |  |  |   |   |   |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><i>John Harris</i>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Mary Unk.</i>   |  |  |  |  |   |   |   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>Emmanuel Lance Trifillis/son</i>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>3028 Darby Street Baltimore, MD 21211</i>   |  |  |  |  |   |   |   |  |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Metro Crematory, Inc.</i>  |  | 20c. Location - City or Town, State<br><i>Baltimore, MD</i>                      |  |  |   |   |   |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Dawn T. McDonald</i>  |   |   |  | 22. Name and Address of Facility<br><i>Cremation Society of Maryland, Inc.<br/>299 Frederick Road Baltimore, MD 21228</i>   |  |  |  |  |   |   |   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |  |   |  |  |  |  |   |   |   |  |  |  |  |
| <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td rowspan="4">}</td> <td>a. <i>Cerebral hemorrhage</i><br/>Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b. _____<br/>Due to (or as a consequence of):</td> </tr> <tr> <td>c. _____<br/>Due to (or as a consequence of):</td> </tr> <tr> <td>d. _____<br/>Due to (or as a consequence of):</td> </tr> </table> |   |   |  |   |  |  |  |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | } | a. <i>Cerebral hemorrhage</i><br>Due to (or as a consequence of): | Approximate Interval Between Onset and Death | b. _____<br>Due to (or as a consequence of): | c. _____<br>Due to (or as a consequence of): | d. _____<br>Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | }   | a. <i>Cerebral hemorrhage</i><br>Due to (or as a consequence of):   | Approximate Interval Between Onset and Death                               |   |  |  |  |  |   |   |   |  |  |  |  |
|   |   | b. _____<br>Due to (or as a consequence of):  |  |   |  |  |  |  |   |   |   |  |  |  |  |
|   |   | c. _____<br>Due to (or as a consequence of):  |  |   |  |  |  |  |   |   |   |  |  |  |  |
|   |   | d. _____<br>Due to (or as a consequence of):  |  |   |  |  |  |  |   |   |   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Small cell carcinoma of lung</i>   |   |   |  |   |  |  |  |  |   |   |   |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |   |  |   |  |  |  |  |   |   |   |  |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |   |  |  |  |  |   |   |   |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |  |   |  |  |  |  |   |   |   |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |   |   |   |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><i>M</i>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how injury occurred                          |   |   |   |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |   |  | 29b. Signature and title of certifier<br><i>Betsy A. Fay MD</i>   |  | 29c. License number<br><i>D33220</i>   |  | 29d. Date signed (Month, Day, Year)<br><i>12/29/97</i>     |   |   |   |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Betsy A. Fay, M.D. 3730 Falls Rd. Baltimore, Md 21211</i>  |   |   |  |   |  |  |  |  |   |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><i>DEC 31 1997</i>   |   |   |  | 32. Registrar's Signature<br><i>John Davidson-Randall</i>   |  |  |  |  |   |   |   |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39864

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Leong M. Vaccaro

2. Date of Death

Dec 18 1997

3. Time of Death

750PM

4a. Facility Name (If not institution, give street and number)

Howard Co. Gen. Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

218-03-6347

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

SEPT 19, 1916

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

CATONSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

213 CHERRYDELL ROAD

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6TH GRADE

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOMEMAKING

17. Father's Name (First, Middle, Last)

HARRY WHITE

18. Mother's Name (First, Middle, Maiden Surname)

19a. Informant's Name/Relationship (Type, Print)

ROBERT VACCARO (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9324 MEADOWHILL ROAD - ELLICOTT CITY, MD. 21042

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTIMORE NAT'L CEMETERY 12/22/97 BALTIMORE

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

HUBBARD FUNERAL HOME INC.

4107 WILKENS AVENUE-BALTIMORE, MD. 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Colon Cancer

Approximate Interval Between Onset and Death

1 year

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

perforated colon

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

D41617

29d. Date signed (Month, Day, Year)

DEC 19, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Gary Kozlow 10805 Hickory Ridge Rd Columbia Md 21045

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

*[Signature]*

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be examined within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



97 39865

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Gladys Vanneman</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>December</b> DAY <b>14</b> YEAR <b>1997</b>   |  |   |  | 3. TIME OF DEATH<br><b>3:15 P.M.</b>  |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-03-7837</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>87</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>May 23, 1910</b>                               |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Pennsylvania</b>                                       |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Mariner Health of Glen Burnie</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Glen Burnie</b>  |  |   |  | 9c. COUNTY OF DEATH<br><b>Anne Arundel</b>  |  |  |  |
| 10a. STATE<br><b>Maryland</b>  |  |  |  | 10b. COUNTY<br><b>Anne Arundel</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Glen Burnie</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO       |  |  |  |
| 10e. STREET AND NUMBER<br><b>7355 East Furnace Brance Road</b>   |  |  |  | 10f. ZIP CODE<br><b>21060</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>11</b>  |  | 15b. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Manager</b>  |  | 16. KIND OF BUSINESS/INDUSTRY<br><b>Retail Sales</b>   |  |   |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles Baker</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Emma Taylor</b>  |  |   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Dorothy Gunshal</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>361 Gatewater Court, Glen Burnie, Maryland 21060</b>                                     |  |   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)  |  | DATE   |  | 20c. LOCATION — City or Town, State   |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Ronald S. Wade, Director</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>State Anatomy Board, 655 W. Baltimore Street<br/>Baltimore, Maryland 21201</b>  |  |   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b><br><b>a. RESPIRATORY FAILURE</b><br><b>b. RECTAL-METASTATIC BREAST CANCER</b><br><b>c.</b><br><b>d.</b><br><b>Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> |  |  |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>- 2 DAYS</b><br><b>- 8 MONTHS</b>                  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>- LIVER AND BONE METASTASIS</b><br><b>- CAROTID ARTERY DISEASE</b>  |  |  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |  |  |   |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
|  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>L. Leidy M.D.</b>  |  |  |  |  |  | 29c. LICENSE NUMBER<br><b>D-22609</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>December 15-1997</b>  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>RUBEN REIDER M.D. 7445 FURNACE BRANCH RD GLEN BURNIE Md 21060</b>  |  |  |  |  |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 31 1997</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |  |  |   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39866

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

John Daffron Walker

2. Date of Death

Month Day Year  
Dec. 26, 1997

3. Time of Death

11:27 AM

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Ctr.

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

217-24-9485

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

67

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 9, 1930

9. Birthplace (State or Foreign Country)

Baltimore, MD

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Edgemere

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2117 Maple Road

10f. Zip Code

21219

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☒ Yes ☐ No  
If Yes, Give  
Year or Dates: 1951-5913. Was Decedent of Hispanic Origin? (Specify Yes or No-  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
9 Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Crane Operator

16b. Kind of Business/Industry

Steel Industry

17. Father's Name (First, Middle, Last)

Charles M. Walker

18. Mother's Name (First, Middle, Maiden Surname)

Annie Halliday

19a. Informant's Name/Relationship (Type, Print)

Mildred E. Walker/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2117 Maple Road Edgemere, Maryland 21219

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Oak Lawn Cemetery 12/30/1997

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Patricia M. Fleming

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. Myocardial infarction  
Due to (or as a consequence of):b. Coronary artery disease  
Due to (or as a consequence of):c. \_\_\_\_\_  
Due to (or as a consequence of):d. \_\_\_\_\_  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Parkinson's Disease

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☒ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
Investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Michael D. Martin MD

29c. License number

D41968

29d. Date signed (Month, Day, Year)

12/29/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Michael D. Martin, MD. 7672 Belair Rd. Balto MD. 21236

31. Date filed (Month, Day, Year)

DEC 31 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39867

|  |  |   |  |   |  |  |  |   |  |
|--|--|---|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Dr. Paul Carl Wainwright</b>                        |   |  |   | 2. Date of Death<br>Month <b>December</b> Day <b>26</b> Year <b>1997</b> |  | 3. Time of Death<br><b>8:00 PM</b>   |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>St. Joseph Medical Center</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Towson</b>                    |  | 4c. County of Death<br><b>Baltimore</b>  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>216-14-8370</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 25, 1919</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |
|  | Usual Residence of Decedent  |   |  |   |  |  |  |   |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 10e. Street and Number<br><b>2807 Summit Avenue</b>  |  |   |  | 10f. Zip Code<br><b>21234</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+)   |  |   |  | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Dentist</b>   |  |  | 16b. Kind of Business/Industry<br><b>Self-employed Dentist</b>                                 |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Fred Wainwright</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Carrie Kellner</b>  |  |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary E. Wainwright (wife)</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2807 Summit Avenue, Baltimore, MD 21234</b>   |  |  |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Mem'l Gard.</b>   |  | Date<br><b>12/30/97</b>  |  | 20c. Location - City or Town, State<br><b>Timonium, Maryland</b>  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Schimunek Funeral Homes, Inc.<br/>9705 Belair Rd., Baltimore, MD 21236</b>   |  |  |  |   |  |
| 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Acute Myocardial Infarction</b><br>Due to (or as a consequence of):<br><br><b>b.</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b> |  |   |  |   |  |  |  | Approximate Interval Between Onset and Death<br><b>Minutes</b>  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |  |
|  |  |   |  |   |  | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  | 29c. License number<br><b>P13272</b>  |  |  |  |   | 29d. Date signed (Month, Day, Year)<br><b>10-30-97</b> |
| 29b. Signature and title of certifier<br>  |  |   |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Robert F. Stoner, MD Suite 506 1205 Sister Pierre M. Towson, MD 21204</b>  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>  |  |   |  | 32. Registrar's Signature<br>   |  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the body-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item 26 Per PHY Film G754 12-31-97 rja

## Certificate of Death

Reg. No.

97 39868

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
ExaminerFuneral  
DirectorPhysician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |  |  |  |                                |   |  |   |  |  |                                     |                                     |                                     |
|---|--|--|--|--|--------------------------------|---|--|---|--|--|-------------------------------------|-------------------------------------|-------------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br><i>James Wallace</i>  |  |  |  | 2. Date of Death<br>Month <i>December</i> Day <i>1</i> Year <i>1997</i>  |                                | 3. Time of Death<br><i>12:45pm</i>  |  |   |  |  |                                     |                                     |                                     |
| 4a. Facility Name (If not institution, give street and number)<br><i>Liberty Medical Center</i>   |  |  |  | 4b. City, Town, or Location of Death<br><i>Baltimore</i>   |                                | 4c. County of Death<br><i>Baltimore</i>   |  |   |  |  |                                     |                                     |                                     |
| 5. Social Security Number<br><i>213-26-3823</i>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><i>69</i> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><i>March 18, 1928</i>  |  |   |  |  |                                     |                                     |                                     |
| 9. Birthplace (State or Foreign Country)<br><i>unknown</i>  |  |  |  |  |                                |   |  |   |  |  |                                     |                                     |                                     |
| Usual Residence of Decedent   |  |  |  |  |                                |   |  |   |  |  |                                     |                                     |                                     |
| 10a. State<br><i>Maryland</i>   |  | 10b. County<br><i>Baltimore City</i>   |  | 10c. City, Town or Location<br><i>Baltimore</i>  |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |  |                                     |                                     |                                     |
| 10e. Street and Number<br><i>2505 Queens Anne Road</i>  |  |  |  | 10f. Zip Code<br><i>21216</i>  |                                | 10g. Citizen of What Country?<br><i>U.S.A.</i>  |  |   |  |  |                                     |                                     |                                     |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>Black</i>   |  |   |  |  |                                     |                                     |                                     |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>unknown</i> College (1-4 or 5+) <i>unknown</i>  |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>unknown</i>  |                                | 16b. Kind of Business/Industry<br><i>unknown</i>  |  |   |  |  |                                     |                                     |                                     |
| 17. Father's Name (First, Middle, Last)<br><i>unknown</i>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>unknown</i>  |                                |   |  |   |  |  |                                     |                                     |                                     |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>unknown</i>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>unknown</i>  |                                |   |  |   |  |  |                                     |                                     |                                     |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <i>in state</i>   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)   |                                | 20c. Location - City or Town, State   |  |   |  |  |                                     |                                     |                                     |
| 21. Signature of Funeral Service Licensee<br><i>Ronald S. Wade, Director</i>  |  |  |  | 22. Name and Address of Facility<br><i>State Anatomy Board, 655 W. Baltimore Street<br/>Baltimore, Maryland 21201</i>  |                                |   |  |   |  |  |                                     |                                     |                                     |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |  |                                |   |  |   |  |  |                                     |                                     |                                     |
| <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a. <i>HEART ATTACK - MYOCARDIAL INFARCTION</i></td> <td rowspan="4">           Approximate Interval Between Onset and Death<br/><br/> <i>5 minutes</i> </td> </tr> <tr> <td>b. Due to (or as a consequence of):</td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> </tr> </table> |  |  |  |  |                                |   |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <i>HEART ATTACK - MYOCARDIAL INFARCTION</i> | Approximate Interval Between Onset and Death<br><br><i>5 minutes</i> | b. Due to (or as a consequence of): | c. Due to (or as a consequence of): | d. Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | a. <i>HEART ATTACK - MYOCARDIAL INFARCTION</i> | Approximate Interval Between Onset and Death<br><br><i>5 minutes</i>   |  |  |                                |   |  |   |  |  |                                     |                                     |                                     |
|   | b. Due to (or as a consequence of):            |  |  |  |                                |   |  |   |  |  |                                     |                                     |                                     |
|   | c. Due to (or as a consequence of):            |  |  |  |                                |   |  |   |  |  |                                     |                                     |                                     |
|   | d. Due to (or as a consequence of):            |  |  |  |                                |   |  |   |  |  |                                     |                                     |                                     |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>diabetes</i>   |  |  |  |  |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |  |  |                                     |                                     |                                     |
|   |  |  |  |  |                                | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |                                     |                                     |                                     |
|   |  |  |  |  |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |                                     |                                     |                                     |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |                                |   |  |   |  |  |                                     |                                     |                                     |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28e. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br>M   |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |                                     |                                     |                                     |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how injury occurred  |                                |   |  |   |  |  |                                     |                                     |                                     |
|   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |                                |   |  |   |  |  |                                     |                                     |                                     |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |  |  |                                |   |  |   |  |  |                                     |                                     |                                     |
| 29b. Signature and title of certifier<br><i>Dr. John Adkins MD</i>  |  |  |  | 29c. License number<br><i>D29968</i>   |                                | 29d. Date signed (Month, Day, Year)<br><i>December 2 1997</i>   |  |   |  |  |                                     |                                     |                                     |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>DR JOHN ADKINS</i>   |  |  |  |  |                                |   |  |   |  |  |                                     |                                     |                                     |
| 31. Date filed (Month, Day, Year)<br><i>DEC 3 1 1997</i>  |  |  |  | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>   |                                |   |  |   |  |  |                                     |                                     |                                     |

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39869

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |                                |  |  |
|---|--|---|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>ALBERT THEODORE WILLINGHAN</b>   |  | 2. Date of Death<br>Month <b>December</b> Day <b>27</b> Year <b>1997</b>  |                                | 3. Time of Death<br><b>6:30pm</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Robosson Court Nursing Home</b>  |  | 4b. City, Town, or Location of Death<br><b>Randallstown</b>   |                                | 4c. County of Death<br><b>Baltimore</b>  |  |
| 5. Social Security Number<br><b>216-03-5690</b>   | 6. Sex<br><b>15</b> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>May 25, 1918</b> |
| 9. Birthplace (State or Foreign Country)<br><b>Baltimore MD</b>   |  |   |                                |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Baltimore</b>   |                                | 10c. City, Town or Location<br><b>Reisterstown</b>   |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |                                |  |  |
| 10e. Street and Number<br><b>11 Walgrove Rd.</b>  |  | 10f. Zip Code<br><b>21136</b>   |                                | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b>   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>   |  |   |                                |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>12</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Freight clerk</b>   |                                | 16b. Kind of Business/Industry<br><b>shipping</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Howard C. Willingham</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Theresa S. Ecker</b>  |                                |  |  |
| 19a. Intendant's Name/Relationship (Type, Print)<br><b>Mildred J. Willingham/wife</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11 Walgrove Rd. Reisterstown, MD 21136</b>  |                                |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Meadowridge Memorial</b>   |                                | 20c. Location - City or Town, State<br><b>Elkridge, MD</b>   |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |  | 22. Name and Address of Facility<br><b>Eline Funeral Home</b><br><b>11824 Reisterstown Rd</b><br><b>Reisterstown, MD 21136</b>  |                                |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Atherosclerotic Coronary Vessel Disease</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. </b><br>Due to (or as a consequence of):<br><b>c. </b><br>Due to (or as a consequence of):<br><b>d. </b> |  | Approximate Interval Between Onset and Death<br><b>10 yrs</b>   |                                |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Alzheimer's Dementia</b>   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown  |                                |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |                                |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |                                | 28b. Time of injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |                                |  |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |                                |  |  |
| 29b. Signature and title of certifier<br><b>Robert L. Mori, MD</b>  |  | 29c. License number<br><b>032882</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>12/29/97</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Robert L. Mori 114 Duinen, Cate, Drive Reisterstown, MD</b>  |  |   |                                |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |                                |  |  |

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39870

|  |  |                       |   |  |  |  |  |  |
|--|--|-----------------------|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>RONALD JOHN WATKINS                                  |                       |   |  | 2. Date of Death<br>Month Day Year<br>December 26, 1997  |  | 3. Time of Death<br>6:30 P.M.  |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br>Howard County General Hospital |                       |   |  | 4b. City, Town, or Location of Death<br>Columbia   |  | 4c. County of Death<br>Howard  |  |
| Funeral<br>Director  | 5. Social Security Number<br>217-50-4330   |                       | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>51 Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>July 28, 1946   | 9. Birthplace (State or Foreign Country)<br>Maryland   |
|  | Usual Residence of Decedent  |                       |   |  |  |  |  |  |
| 10a. State<br>Md.  |  | 10b. County<br>Howard |   | 10c. City, Town or Location<br>Ellicott City   |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br>3011 Pebble Beach Drive  |  |                       |   | 10f. Zip Code<br>21042   |  | 10g. Citizen of What Country?<br>USA   |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |                       | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+) 4 Yrs. College  |  |                       |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Labor Relations |  |  | 16b. Kind of Business/Industry<br>Government   |  |
| 17. Father's Name (First, Middle, Last)<br>James G. Watkins  |  |                       |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Lavinia Truitt  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Cassandra M. Watkins (Wife)  |  |                       |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3011 Pebble Beach Drive Ellicott City, Md. 21042  |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Carroll Cremation Service   |  | Date<br>12/30/97   |  | 20c. Location - City or Town, State<br>Hampstead, Md.  |  |
| 21. Signature of Funeral Service Licensee<br><i>Rene B. Elmer</i>  |  |                       |   |  | 22. Name and Address of Facility<br>11824 Reisterstown Road<br>ELINE FUNERAL HOME Reisterstown, Md. 21136  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. Malignant Ventricular Arrhythmia Due to (or as a consequence of): seconds<br>b. Acute Myocardial Infarction Due to (or as a consequence of): hour<br>c. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): years<br>d. Hypercholesterolemia Due to (or as a consequence of): years |  |                       |   |  |  |  |  | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |                       |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |
|  |  |                       |   |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |                       | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |                       | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No    |  |
| 28d. Describe how injury occurred  |  |                       |   |  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| 28f. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |                       |   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |                       | 29b. Signature and title of certifier<br><i>Patricia A. Tate MD</i>   |  |  | 29c. License number<br>D31473  |  | 29d. Date signed (Month, Day, Year)<br>Dec 29, 1997  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>PATRICIA A. TATE, MD 4565 Hemlock Cove Way Ellicott City MD 21042  |  |                       |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>DEC 31 1997   |  |                       | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

15

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39871

|   |  |  |   |                                |   |  |  |  |
|---|--|--|---|--------------------------------|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Ida Amelia Williams  |  |   |                                | 2. Date of Death<br>Month Day Year<br>Dec 28 1997   |  | 3. Time of Death<br>1810   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>St. Agnes Healthcare   |  |   |                                | 4b. City, Town, or Location of Death<br>Baltimore   |  | 4c. County of Death<br>N/A   |  |
| Funeral<br>Director   | 5. Social Security Number<br>216-07-4763   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>90 Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth<br>(Month, Day, Year)<br>MAY 23, 1907   | 9. Birthplace (State or Foreign Country)<br>Maryland                                 |  |
|   | Usual Residence of Decedent  |  |   |                                |   |  |  |  |
| To Be Completed by Funeral Director   | 10e. State<br>Md.  | 10b. County<br>Howard  | 10c. City, Town or Location<br>Elkridge   |                                |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |
|   | 10e. Street and Number<br>6391 Rowanberry Dr.  |  |   | 10f. Zip Code<br>21075         |   | 10g. Citizen of What Country?<br>USA   |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Navar Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: white                     |  |
|   | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) Collage (1-4 or 5+)<br>12  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>Supervisor                            |                                | 16b. Kind of Business/Industry<br>Neck Wear   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Nelson Smith  |  |   |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>Ida M. Marks   |  |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>Joe Beall - Grandson   |  |   |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5235 Stone Bridge Way, Sykesville, Md. 21784   |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Meadowridge Mem. Park   |                                | Data<br>1/02/98   | 20c. Location - City or Town, State<br>Elkridge, Md.   |  |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br>Gary L. Kaufman Funeral Home at Meadowridge MP<br>7250 Washington Blvd., Elkridge, Md. 21075                      |                                |   |  |  |  |
|   | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. RESPIRATORY ARREST<br>Due to (or as a consequence of):<br>b. CARDIAC ARREST<br>Due to (or as a consequence of):<br>c. ASPIRATION<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br>10 min.<br>10 min.<br>10 min. |  |   |                                |   |  |  |  |
|   | 23f. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>ATRIAL FIBRILLATION   |  |   |                                |   |  |  |  |
| State<br>Registrar  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |                                | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury<br>(Month, Day Year)  |                                | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
|   | 29a. Certifier<br>(Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |                                | 29b. Signature and title of certifier<br>   |  |  |  |
|   | 29c. License number<br>D 4-2496  |  |   |                                | 29d. Date signed (Month, Day, Year)<br>12 28, 97  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>M.A. BORTONE, MD 900 CALLOW AVE BALTIMORE, MD 21229 |  |  |   |                                |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>DEC 31 1997  |  |  |   | 32. Registrar's Signature<br>  |   |  |  |  |

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

NAME: Ida Amelia Williams  
Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item 19a Per FH Film G755 1-14-98 rja

Certificate of Death

Reg. No.

97 39872

|  |  |  |  |   |   |   |   |  |
|--|--|--|--|---|---|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>PAULINE WASSERMAN</b>   |  |  |   | 2. Date of Death<br>Month <b>DEC</b> Day <b>26</b> Year <b>97</b>   |   | 3. Time of Death<br><b>11:17 PM</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>1611 WOODLANDS RUN</b>  |  |  |   | 4b. City, Town, or Location of Death<br><b>HAGERSTOWN</b>   |   | 4c. County of Death<br><b>WASHINGTON</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>364-16-8138</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth<br>(Month, Day, Year)<br><b>FEB. 22, 1912</b>  | 9. Birthplace (State or Foreign Country)<br><b>ENGLAND</b> |
|  | Usual Residence of Decedent  |  |  |   | 10c. City, Town or Location<br><b>HAGERSTOWN</b>  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>WASHINGTON</b>   |   | 10e. Street and Number<br><b>1611 WOODLANDS RUN</b>   |   | 10f. Zip Code<br><b>21742</b>   |  |
|  | 10g. Citizen of What Country?<br><b>USA</b>  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |   | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>XX</b>   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>XX</b> |  |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOUSEWIFE</b>   |   | 16b. Kind of Business/Industry<br><b>OWN HOME</b>   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>UNKNOWN</b>  |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ANNIE SILVERMAN</b>   |   |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>DIANE SIMON DAUGHTER</b>  |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1611 WOODLANDS RUN; HAGERSTOWN, MD 21742</b>  |   |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>HEBREW MEMORIAL PARK</b>  |   | 20c. Location - City or Town, State<br><b>12-28-1997 MT.CLEMENTS, MI</b>  |   | 20d. Date   |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Michael Kruger</i>   |  |  |   | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS, INC</b><br><b>8900 REISTERSTOWN RD; PIKESVILLE, MD 21208</b>  |   |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Metastatic Breast Cancer</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |  |   |   |   |   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>23b. Did tobacco use contribute to the cause of death?</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown<br><br><b>24a. Was an autopsy performed?</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><br><b>24b. Were autopsy findings available prior to completion of cause of death?</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |   |   |   |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of injury (Month, Day, Year) |  | 28b. Time of injury<br>M  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 28d. Describe how injury occurred  |  |  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |  |
| 29b. Signature and title of certifier<br><i>Michael J. McCormack MD</i>  |  |  |  | 29c. License number<br><b>041667</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>12.27.97</b>                                      |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Michael J. McCormack 11110 Medical Campus Rd Suite 130 Hagerstown MD 21742</b>  |  |  |  |   |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>  |  |  |  | 32. Registrar's Signature<br><i>J. Davidson-Randall</i>   |   |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

15

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

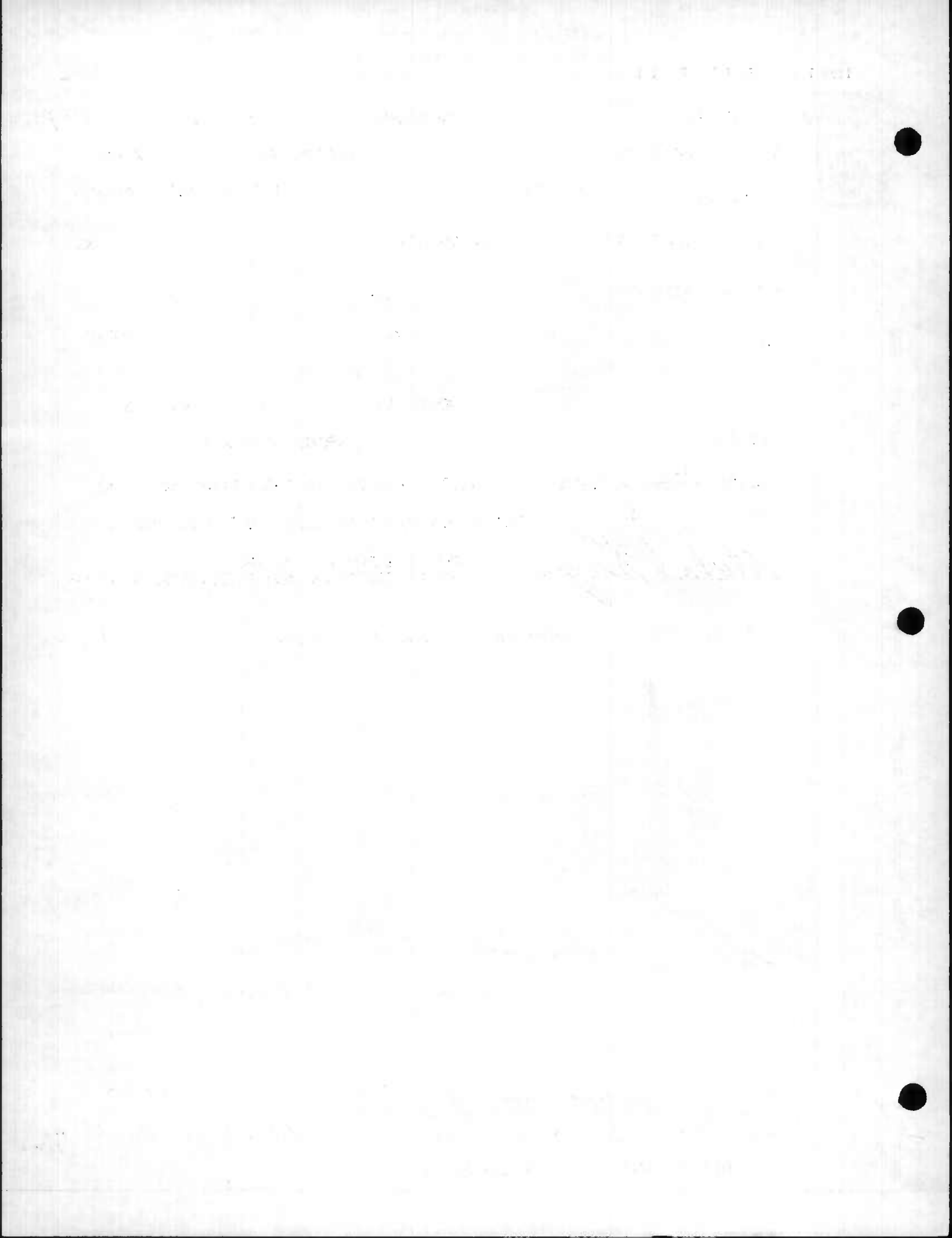
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

T

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



97 39873

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>FLORENCE VIRGINIA WAGNER  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>12 28 97  |  | 3. TIME OF DEATH<br>1:30 P. M.  |  |
| 4. SOCIAL SECURITY NUMBER<br>215-03-5531  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>85 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>SEPT 24, 1912  |  |
| 8a. FACILITY NAME (If not Institution, give street and number)<br>WESLEY HOME, INC  |  |  |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE  |  | 8c. COUNTY OF DEATH<br>N/A  |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |  |
| 10a. STATE<br>MD  |  | 10b. COUNTY<br>BALTIMORE   |  | 10c. CITY, TOWN OR LOCATION<br>HALETHORPE   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>1821 PARK AVENUE  |  |  |  | 10f. ZIP CODE<br>21227  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE                                    |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11TH GRADE<br>College (1-4 or 5+) _____  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>HOMEMAKER  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>OWN HOME  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>WALTER PADGETT   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>CLARA MATILDA BUSH   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>FLORENCE M. SLATTERY (NIECE)  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4201 FORDHAM ROAD - BALTIMORE, MD 21229  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify) _____   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>DRUID RIDGE CEMETERY  |  | DATE<br>12/31/97  |  | 20c. LOCATION — City or Town, State<br>PIKESVILLE, MD   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>HUUBARD FUNERAL HOME INC.<br>4107 WILKENS AVENUE-BALTIMORE, MD 21229  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE RESPIRATORY FAILURE<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. BRONCHOPNEUMONIA<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. _____<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____<br>Approximate Interval Between Onset and Death<br>ACUTE<br>1 DAY<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>CEREBROVASCULAR DISEASE; CORONARY ARTERY DISEASE WITH CARDIOMYOPATHY<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____ |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Robert E. Roby M.D.</i>   |  |  |  | 29c. LICENSE NUMBER<br>D-19425  |  | 29d. DATE SIGNED (Month, Day, Year)<br>12/30/97   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>ROBERT E. ROBY, M.D. 2211 W. ROGERS AVE. 21209   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>DEC 31 1997  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randell</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

39874

Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: if item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

Division of Vital Records, P.O. Box 68769  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>SARA MATILDA WHITE</b>  |  | 2. Date of Death<br>Month Day Year<br><b>DECEMBER 25, 1997</b>  |  | 3. Time of Death<br><b>1:10 A.M.</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>4404 NORFEN ROAD</b>  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death<br><b>BALTIMORE</b>  |  |
| 5. Social Security Number<br><b>217-07-5347</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>JULY 19, 1920</b>  |
| 9. Birthplace (State or Foreign Country)<br><b>BALTIMORE</b>   |  |   |  |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>BALTIMORE</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |
| 10e. Street and Number<br><b>4404 NORFEN ROAD</b>  |  | 10f. Zip Code<br><b>21227</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9TH GRADE</b>  |  | College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>MAIL CLERK</b>   |  |
| 16b. Kind of Business/Industry<br><b>FACTORY</b>   |  |   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>(UNKNOWN) GIBSON</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>DAISEY (UNKNOWN)</b> |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>KIMBERLY E. SCHUCH (DAUGHTER)</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4404 NORFEN ROAD - BALTIMORE, MD 21227</b>  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GLEN HAVEN MEMORIAL PARK</b>   |  | 20c. Location - City or Town, State<br><b>12/29/97 BALTIMORE</b>   |  |
| 21. Signature of Funeral Service Licensee<br><i>Jackie D. Shannon</i>  |  | 22. Name and Address of Facility<br><b>HUBBARD FUNERAL HOME INC.<br/>4107 WILKENS AVENUE-BALTIMORE, MD 21229</b>  |  |  |  |
| 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Chronic arteriosclerotic disease</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |  |  | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic pulmonary disease</b>   |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
|  |  |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|  |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  |
|  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |
|  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |
| 29b. Signature and title of certifier<br><b>Laurence R. Gallagher, MD</b>  |  | 29c. License number<br><b>DD1786</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>Dec 26 1997</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DR. LAURENCE GALLAGHER - 716 MAIDEN CHOICE LANE-SUITE 101-CATONSVILLE, MD 21228</b>   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>  |  | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>  |  |  |  |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39875

|                                     |   |  |  |                                |  |  |  |  |
|-------------------------------------|---|--|--|--------------------------------|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Louis Washington</b>   |  |  |                                | 2. Date of Death<br>Month <b>NOV.</b> Day <b>19</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>08:18 AM</b>  |  |
|                                     | 4a. Facility Name (If not institution, give street and number)<br><b>LAUREL REGIONAL HOSPITAL</b>   |  |  |                                | 4b. City, Town, or Location of Death<br><b>LAUREL</b>  |  | 4c. County of Death<br><b>PRINCE GEORGES</b>   |  |
| Funeral<br>Director                 | 5. Social Security Number<br><b>unknown</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>57</b> Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Oct, 21, 1940</b>                                    |  | 9. Birthplace (State or Foreign Country)<br><b>unknown</b> |
|                                     | Usual Residence of Decedent   |  |  |                                |  |  |  |  |
| To Be Completed by Funeral Director | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Laurel</b>   | 10c. City, Town or Location<br><b>Laurel</b>   |                                |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
|                                     | 10e. Street and Number<br><b>11703 South Laurel Drive, Apt 1032</b>   |  |  | 10f. Zip Code<br><b>20708</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |
|                                     | 11. Mental Status <b>unknown</b><br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>unknown</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |
|                                     | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>unknown</b><br>College (1-4 or 5+) <b>unknown</b>   |  | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>unknown</b>  |                                | 16b. Kind of Business/Industry<br><b>unknown</b>   |  |  |  |
|                                     | 17. Father's Name (First, Middle, Last)<br><b>unknown</b>   |  |  |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>unknown</b>  |  |  |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br><b>unknown</b>  |  |  |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>unknown</b>  |  |  |  |
|                                     | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>in state</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>in state</b>  |                                | Data   |  | 20c. Location - City or Town, State  |  |
|                                     | 21. Signature of Funeral Service Licensee<br><b>Ronald S. Wade, Director</b>  |  |  |                                | 22. Name and Address of Facility<br><b>State Anatomy Board, 655 W. Baltimore Street<br/>Baltimore, Maryland 21201</b>  |  |  |  |
|                                     | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>a. Atherosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):<br><b>b.</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b>          |  |  |                                |  |  |  |  |
|                                     | 23e. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |                                |  |  |  |  |
| Physician<br>/Medical<br>Examiner   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |  |                                |  |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |
|                                     |   |  |  |                                |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|                                     | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> OOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |  |  |  |  |
|                                     | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)  |                                | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|                                     |   |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |                                | 28d. Describe how injury occurred  |  |  |  |
|                                     |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |                                |  |  |  |  |
|                                     | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |                                |  |  |  |  |
|                                     | 29b. Signature and title of certifier<br><b>Stephen S. Radentz, MD</b>  |  |  |                                | 29c. License number<br><b>O.C.M.E</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>NOV. 20, 1997</b>  |  |
|                                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201</b>  |  |  |                                |  |  |  |  |
|                                     | 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>   |  | 32. Registrar's Signature<br><b>John Davidson-Randall</b>  |                                |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39876

|   |  |   |  |  |   |  |  |  |
|---|--|---|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ROWLAND MARSDEN YOUNGER</b>                         |   |  |  | 2. Date of Death<br>Month <b>Dec.</b> Day <b>28,</b> Year <b>1997</b> |  | 3. Time of Death<br><b>3:10 p.m.</b>   |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>Fallston General Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Fallston</b>               |  | 4c. County of Death<br><b>Harford</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>218-10-9531</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs. | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Days  | 8. Date of Birth (Month, Day, Year)<br><b>April 7, 1921</b>                      | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                    |  |
|   | Usual Residence of Decedent  |   |  |  |   |  |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Harford</b>   |  | 10c. City, Town or Location<br><b>Forest Hill</b>  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>1700 F. Landmark Drive</b>   |  |   |  | 10f. Zip Code<br><b>21050</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>          |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4 years</b> College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Engineer</b>   |   | 16b. Kind of Business/Industry<br><b>Martin Marietta</b>                         |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Samuel G. Younger</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ruth Campbell</b>  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Evelyn L. Younger (Wife)</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1700 F. Landmark Drive, Forest Hill, MD. 21050</b>                                       |   |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Green Mount Crematory</b>  |  | Date<br><b>1/1/98</b>  |   | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>                |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Schimunek Funeral Home of Bel Air, Inc.<br/>610 W. MacPhail Road, Bel Air, MD. 21014</b>  |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Cardiac Disease</b><br>Due to (or as a consequence of):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Approximate Interval Between Onset and Death<br><b>years</b> |  |   |  |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |   |  |  |   |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred   |  |   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |   |  |  |  |
| 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br><b>D32299</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>December 29, 1997</b>                  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>David S. Dunn M.D., 615 W. MacPhail Road, Bel Air, MD. 21014</b>   |  |   |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>   |  |   |  | 32. Registrar's Signature<br>   |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,







Items: 23a part I, 27 per MEO G-755 1/15/98 dh

State of Maryland / Department of Health and Mental Hygiene

### Certificate of Death

Reg. No.

<sup>e</sup>97 39878

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39879

Item: 20b Per FH Film G-754 1-2-98RC

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

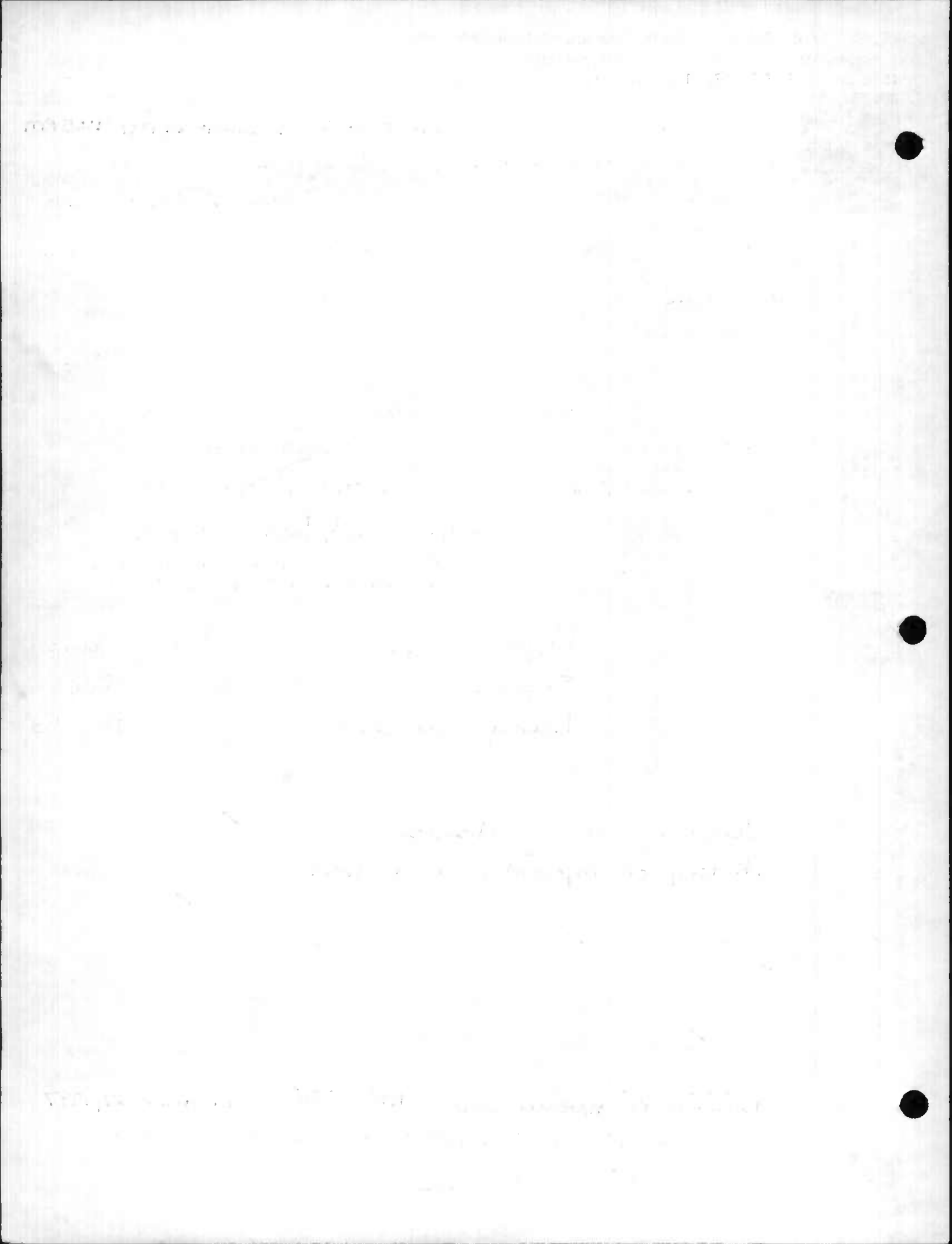
Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Physician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |   |  |  |   |   |   |  |   |    |
|--|--|---|---|--|--|---|---|---|--|---|----|
| 1. Decedent's Name (First, Middle, Last)<br><b>Gloria Zeranko</b>  |  | 2. Date of Death<br>Month <b>December</b> Day <b>27</b> Year <b>1997</b>  |   | 3. Time of Death<br><b>9:05 PM</b>   |  |   |   |   |  |   |    |
| 4a. Facility Name (If not institution, give street and number)<br><b>Johns Hopkins Bayview Medical Ctr.</b>  |  | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>   |   | 4c. County of Death<br><b>N/A</b>  |  |   |   |   |  |   |    |
| 5. Social Security Number<br><b>188-32-3969</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>56</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>June 16, 1941</b> | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>  |  |   |   |   |  |   |    |
| Usual Residence of Decedent  |  |   |   |  |  |   |   |   |  |   |    |
| 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Baltimore</b>  | 10c. City, Town or Location<br><b>Dundalk</b>   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |   |  |   |    |
| 10e. Street and Number<br><b>41 Wise Ave.</b>  |  | 10f. Zip Code<br><b>21222</b>   |   | 10g. Citizen of What Country?<br><b>United States</b>  |  |   |   |   |  |   |    |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   |   |   |  |   |    |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2 Years</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Accountant</b>   |  |   |   |   |  |   |    |
| 16b. Kind of Business/Industry<br><b>Accounting</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>Franklin Sewalish</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Catherine Asashon</b>  |  |   |   |   |  |   |    |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Richard J. Zeranko/Son</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>41 Wise Ave. Dundalk, Maryland 21222</b>  |   |  |  |   |   |   |  |   |    |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holy Family Cemetery</b>   |   | 20c. Location - City or Town, State<br><b>Colver, PA</b>   |  |   |   |   |  |   |    |
| 20d. Date<br><b>1/2/1998</b>   |  | 20e. Date<br><b>1/2/1997</b>  |   |  |  |   |   |   |  |   |    |
| 21. Signature of Funeral Service Licensee<br><b>Johnny L. [Signature]</b>  |  | 22. Name and Address of Facility<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.<br/>7922 Wise Ave. Dundalk, Maryland 21222</b>   |   |  |  |   |   |   |  |   |    |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |   |  |  |   |   |   |  |   |    |
| <table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a. <b>Hypotension</b><br/>Due to (or as a consequence of):</td> <td rowspan="4">           Approximate Interval Between Onset and Death<br/><br/>           Hours<br/>Days<br/>Months         </td> </tr> <tr> <td>b. <b>Sepsis</b><br/>Due to (or as a consequence of):</td> </tr> <tr> <td>c. <b>Lung cancer</b><br/>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> </tr> </table> |  |   |   |  |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <b>Hypotension</b><br>Due to (or as a consequence of): | Approximate Interval Between Onset and Death<br><br>Hours<br>Days<br>Months | b. <b>Sepsis</b><br>Due to (or as a consequence of): | c. <b>Lung cancer</b><br>Due to (or as a consequence of): | d. |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | a. <b>Hypotension</b><br>Due to (or as a consequence of):                  | Approximate Interval Between Onset and Death<br><br>Hours<br>Days<br>Months   |   |  |  |   |   |   |  |   |    |
|  | b. <b>Sepsis</b><br>Due to (or as a consequence of):                       |   |   |  |  |   |   |   |  |   |    |
|  | c. <b>Lung cancer</b><br>Due to (or as a consequence of):                  |   |   |  |  |   |   |   |  |   |    |
|  | d.   |   |   |  |  |   |   |   |  |   |    |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Coronary artery disease</b><br><b>History of myocardial infarction</b>  |  |   |   |  |  |   |   |   |  |   |    |
| 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |   |  |  |   |   |   |  |   |    |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |   |   |   |  |   |    |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |   |   |  |   |    |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  |   |   |   |  |   |    |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |   |  |  |   |   |   |  |   |    |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |   |   |   |  |   |    |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |   |  |  |   |   |   |  |   |    |
| 29b. Signature and title of certifier<br><b>Kristine Bienvenu MD</b>   |  | 29c. License number<br><b>RES-000</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>December 27, 1997</b>  |  |   |   |   |  |   |    |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Kristine Bienvenu, MD Johns Hopkins Bayview Med. Ctr. Baltimore, Maryland</b>   |  |   |   |  |  |   |   |   |  |   |    |
| 31. Date filed (Month, Day, Year)<br><b>DEC 31 1997</b>  |  | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>  |   |  |  |   |   |   |  |   |    |

State  
Registrar



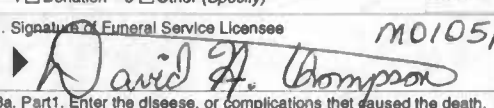
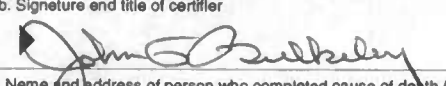
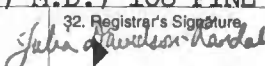
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39880

|  |   |  |  |   |  |   |   |   |
|--|---|--|--|---|--|---|---|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>JAMES RUSSELL ADKINS SR.</b>               |  |  |   | 2. Date of Death<br>Month <b>12</b> Day <b>05</b> Year <b>97</b> |   | 3. Time of Death<br><b>1030</b>                           |   |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>9375 RIGGIN ROAD</b> |  |  |   | 4b. City, Town, or Location of Death<br><b>MARDELA</b>           |   | 4c. County of Death<br><b>WICOMICO</b>                    |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>577-26-4030</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.  | If Under 1 Year<br>Months Days                                   | If Under 24 Hrs.<br>Hours Min.  | 6. Date of Birth<br>(Month, Day, Year)<br><b>08-20-16</b> | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
|  | Usual Residence of Decedent   |  |  |   | 10a. State<br><b>Maryland</b>                                    |   | 10b. County<br><b>Wicomico</b>                            |   |
|  |   |  |  | 10c. City, Town or Location<br><b>Mardela Springs</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |
| 10e. Street and Number<br><b>9375 Riggins Road</b>   |   |  |  | 10f. Zip Code<br><b>21837</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |   |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW II</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>-</b>  |   |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Owner</b>   |  | 16b. Kind of Business/Industry<br><b>Hardware &amp; Farm Supply</b>   |   |   |
| 17. Father's Name (First, Middle, Last)<br><b>Russell Taylor Adkins</b>  |   |  |  | 16. Mother's Name (First, Middle, Maiden Surname)<br><b>Nina Dashiell Bradley</b>   |  |   |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>James R. Adkins Jr./Son</b>   |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4628 Broken Lute Way, Ellicott City, MD 21042</b>   |  |   |   |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mardela Memorial Cemetery</b>   |  | Date<br><b>12/9/97</b>  |  | 20c. Location - City or Town, State<br><b>Mardela Springs, MD</b>   |   |   |
| 21. Signature of Funeral Service Licensee<br> <b>MD01051</b>   |   |  |  | 22. Name and Address of Facility<br><b>Holloway Funeral Home</b><br><b>501 Snow Hill Rd., Salisbury, MD 21804</b>   |  |   |   |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of): |   |  |  |   |  |   |   |   |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |  |   |  |   |   |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   |   |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |   |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |  | 28d. Describe how injury occurred   |  |   |   |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |   |  |   |   |   |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |  |  |   |  |   |   |   |
| 29b. Signature and title of certifier<br> <b>D.M.E.</b>   |   |  |  | 29c. License number<br><b>D03599</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>12-05-97</b>  |   |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>JOHN T. BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY MD 21801</b>   |   |  |  |   |  |   |   |   |
| 31. Date filed (Month, Day, Year)<br><b>DEC 10 1997</b>  |   |  |  | 32. Registrar's Signature<br>  |  |   |   |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #1 WCHD 12/10/97

## Certificate of Death

Reg. No.

|   |  |   |  |  |   |   |   |  |
|---|--|---|--|--|---|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last) <u>Olivia Milbourne Ames</u>  |   |  |  | 2. Date of Death<br>Month <u>12</u> Day <u>3</u> Year <u>97</u> |   | 3. Time of Death<br><u>6:50P</u>                                |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><u>Levinale Hebrew Geriatric Center + Hosp. Inc.</u> |   |  |  | 4b. City, Town, or Location of Death<br><u>Baltimore MD</u>     |   | 4c. County of Death<br><u>BALTIMORE</u>                         |  |
| Funeral<br>Director   | 5. Social Security Number<br><u>219-03-7680</u>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><u>(79)</u> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><u>2-14-18</u>           |   | 9. Birthplace (State or Foreign Country)<br><u>ACCOMAC, VA.</u> |  |
|   | Usual Residence of Decedent  |   |  |  |   |   |   |  |
| 10a. State<br><u>MD.</u>  |  | 10b. County<br><u>BALTIMORE</u>   |  | 10c. City, Town or Location<br><u>BALTIMORE</u>  |   |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
| 10e. Street and Number<br><u>4023 FALLSTAFF ROAD</u>  |  |   |  | 10f. Zip Code<br><u>21215</u>  |   | 10g. Citizen of What Country?<br><u>USA</u>   |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>AFRO-AMERICAN</u>             |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><u>Elementary/Secondary (0-12)</u><br><u>8th</u>   |  |   |  | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>DOMESTIC</u>   |   | 16b. Kind of Business/Industry<br><u>HOUSEKEEPER</u>  |   |  |
| 17. Father's Name (First, Middle, Last)<br><u>WILSON BRITTINGHAM</u>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>ELLA MAE KNOX</u>  |   |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>BESSIE BISHOP</u>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>2391 WORCESTER HIGHWAY; POCOMOKE CITY, MD. 21851</u>                                     |   |   |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>JOHNSON NECK CEMETERY</u>  |  | Date<br><u>12-13</u>   |   | 20c. Location - City or Town, State<br><u>POCOMOKE CITY, MD.</u>                            |   |  |
| 21. Signature of Funeral Service Licensee<br><u>Loretta L. Jolley</u>   |  |   |  | 22. Name and Address of Facility<br><u>JOLLEY MEMORIAL CHAPEL</u><br><u>1213 JERSEY ROAD; SALISBURY, MD. 21801</u>   |   |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <u>Chronic obstructive pulmonary disease</u><br>Due to (or as a consequence of):<br><br>b. <u>Cachexia</u><br>Due to (or as a consequence of):<br><br>c. _____<br>Due to (or as a consequence of):<br><br>d. _____<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |   |   |   | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA                       |  | 26. Place of Death (Check only one)<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify)                   |   |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><u>M</u>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred  |
|   |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br><u>[Signature]</u>   |  | 29c. License number<br><u>D 10660</u>  |   | 29d. Date signed (Month, Day, Year)<br><u>12/6/97</u>                                       |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>DEBRA WERTHIEMER; 2434 W. BELVEDERE RD; BALTIMORE, MD. 21215</u>   |  |   |  |  |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><u>DEC 10 1997</u>   |  | 32. Registrar's Signature<br><u>[Signature]</u>   |  |  |   |   |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Ames Olivia  
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

2

State  
Registrar



97 39882

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |  |
|--|--|--|--|---|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Augustus Thompson Boyd</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Dec. 4 1997</b>  |  | 3. TIME OF DEATH<br><b>9:42 PM</b>  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-18-2660</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>73</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Mar. 1 1924</b>                                       |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>113 Prices Lane</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Chester</b>   |  | 9c. COUNTY OF DEATH<br><b>Queen Anne</b>  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Queen Anne</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Chester</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |  |
| 10e. STREET AND NUMBER<br><b>P.O. Box 37</b>   |  |  |  | 10f. ZIP CODE<br><b>21619</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>   |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>                      |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (8-12) <b>12</b> College (1-4 or 5+) <b>12</b>   |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Laborer</b>   |  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>None</b>   |  |   |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Eddie Boyd</b>   |  |  |  | 16. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Amelia Ann Jackson</b>  |  |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Lois Boyd (Wife)</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 37 Chester, Md. 21619</b>  |  |   |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Union Wesley</b>   |  | DATE<br><b>12/13</b>  |  | 20c. LOCATION — City or Town, State<br><b>Chester, Md.</b>                                      |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Glady B. Stewart</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Stewart Funeral Home<br/>821 West Rd. Salisbury, Md. 21801</b>   |  |   |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Ischemic cardiomyopathy</b><br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Arteriosclerosis, general and coronary</b><br><br><b>Renal failure, Diabetes mellitus type II</b> |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br><b>1 1/2 years</b><br><b>many years</b><br><b>—</b><br><b>—</b>                         |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Renal failure, Diabetes mellitus type II</b>  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |   |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Charles W. Kinzer MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D05928</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>December 9, 1997</b>                                  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Charles W. Kinzer MD, 2003 Medical Parkway, Annapolis, MD 21401</b>  |  |  |  |   |  |   |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 10 1997</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>Jane Davidson-Randall</b>  |  |   |  |   |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

12

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

X

X

2. 2nd of August

2. 2nd of August

2. 2nd of August

2. 2nd of August

2. 2nd of August

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39883

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician  
/Medical  
Examiner

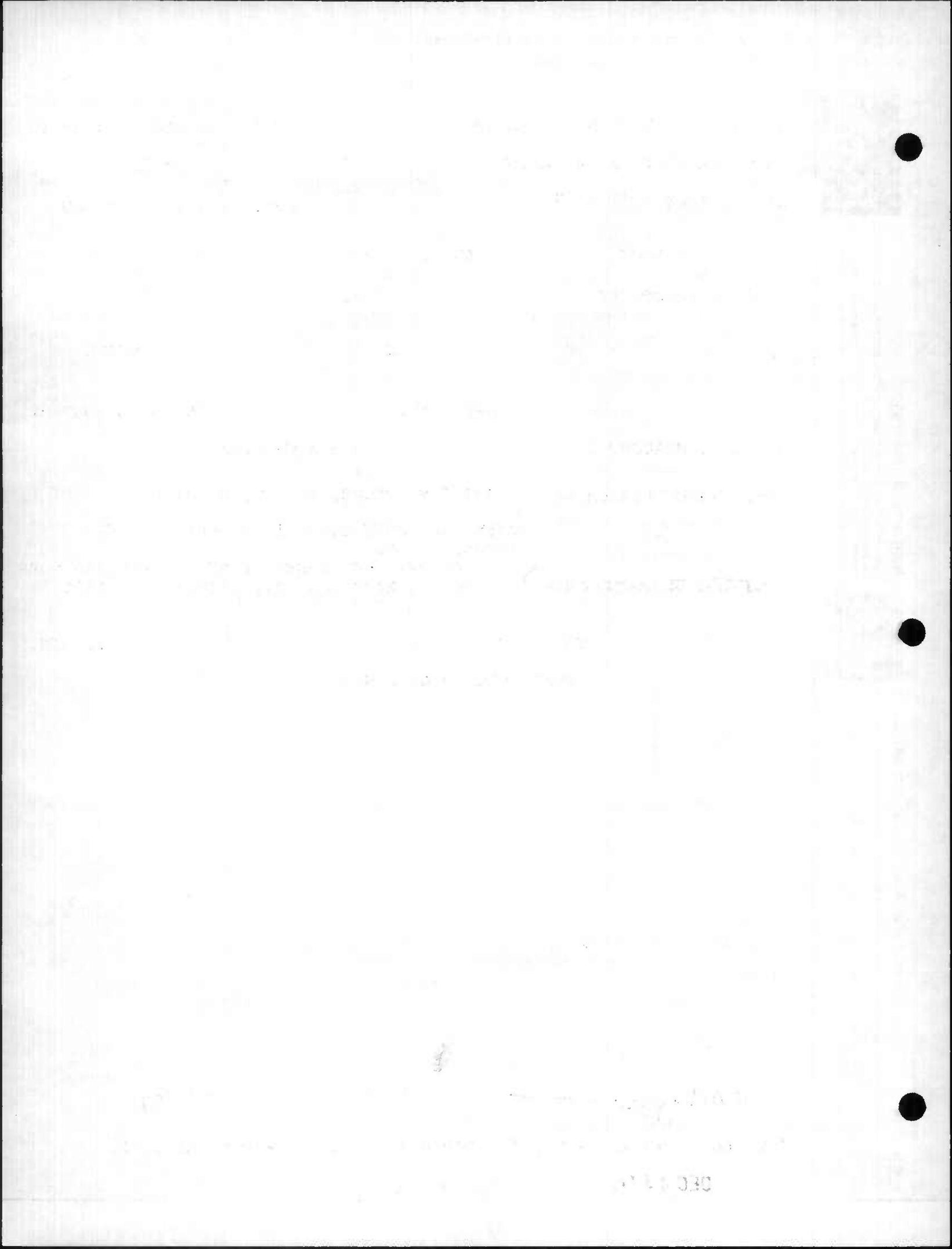
Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |  |                                |  |  |
|---|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>AGNES SLAUGHTER CLAGGETT</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>DEC. 7 1997</b>   |                                | 3. Time of Death<br><b>5:45 PM</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>MEMORIAL HOSPITAL @ EASTON</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>EASTON</b>  |                                | 4c. County of Death<br><b>TALBOT</b>   |  |
| 5. Social Security Number<br><b>217-12-4584</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>AUG. 9, 1921</b>                                     |  |
| 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |  |   |  |  |                                |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>TALBOT</b>  |  | 10c. City, Town or Location<br><b>EASTON</b>   |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>411 S. HANSON ST.</b>  |  |   |  | 10f. Zip Code<br><b>21601</b>  |                                | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>-0-</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SECRETARY</b>  |                                | 16b. Kind of Business/Industry<br><b>INSURANCE COMPANY</b>                                     |  |
| 17. Father's Name (First, Middle, Last)<br><b>JAMES G. SLAUGHTER</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>EVA CALLAHAN</b>   |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>JAMES MASON SLAUGHTER</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>303 ELM AVENUE, EASTON, MD 21601</b>   |                                |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CHESAPEAKE CREMATION CENTER, I.L.C.</b>  |  | Date<br><b>12-9</b>  |                                | 20c. Location - City or Town, State<br><b>CHESTER, MD</b>                                      |  |
| 21. Signature of Funeral Service Licensee<br><b>JOHN R. MERCERO</b>   |  |   |  | 22. Name and Address of Facility<br><b>FELLOWS, HELFENBEIN &amp; NEWNAM FUNERAL HOME<br/>200 S. HARRISON ST., EASTON, MD 21601</b>   |                                |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>PULMONARY EMBOLISM</b><br><b>METASTATIC COLON CANCER</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br><br>Approximate Interval Between Onset and Death<br><b>10 MIN.</b> |  |   |  |  |                                |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |                                |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |  |                                |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                                |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |                                |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28d. Describe how injury occurred  |                                |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |                                |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |                                |  |  |
| 29b. Signature and title of certifier<br><b>Richard Burgoyne</b>  |  |   |  | 29c. License number<br><b>D42816</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>12/1/97</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>RICHARD BURGOYNE, M.D., 607 DUTCHMAN'S LANE, EASTON, MD 21601</b>  |  |   |  |  |                                |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 09 1997</b>   |  |   |  | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>   |                                |  |  |

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39884

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
Examiner

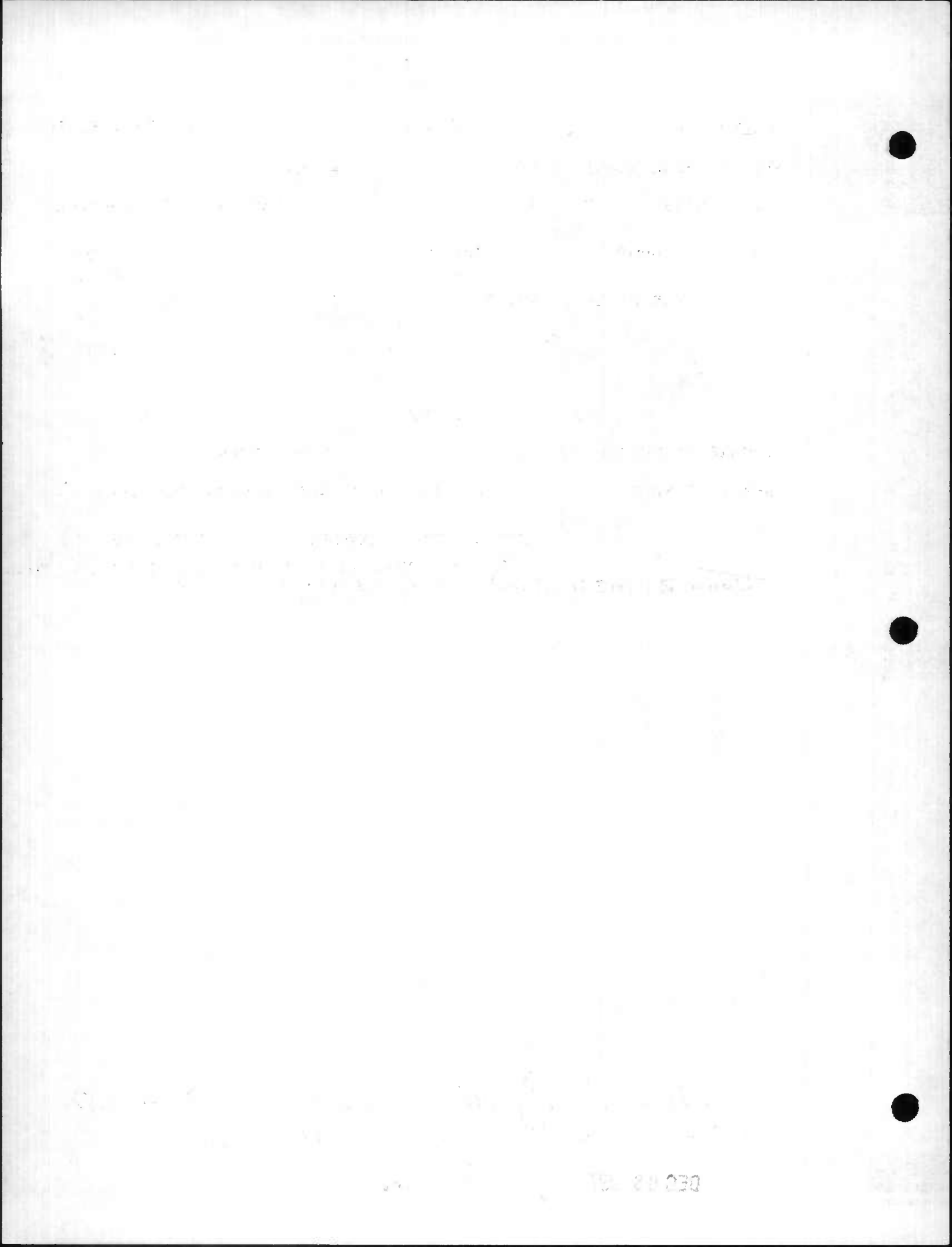
Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |  |   |                                |  |   |
|--|--|---|--|---|--------------------------------|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>GWENDOLYN S. Collier</b>  |  |   |  | 2. Date of Death<br>Month <b>Dec.</b> Day <b>05</b> , Year <b>1997</b>  |                                | 3. Time of Death<br><b>6:45pm</b>  |   |
| 4a. Facility Name (If not institution, give street and number)<br><b>WILLIAM HILL HEALTH CARE</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>EASTON</b>   |                                | 4c. County of Death<br><b>TALBOT</b>   |   |
| 5. Social Security Number<br><b>213-01-8248</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>MAY 18, 1917</b>   |   |
| 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |  |   |  |   |                                |  |   |
| Usual Residence of Decedent  |  |   |  |   |                                |  |   |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>TALBOT</b>  |  | 10c. City, Town or Location<br><b>EASTON</b>  |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |
| 10e. Street and Number<br><b>501 DUTCHMAN'S LANE, APT. 320</b>   |  |   |  | 10f. Zip Code<br><b>21601</b>   |                                | 10g. Citizen of What Country?<br><b>USA</b>  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>-0-</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SECRETARY</b>   |                                | 16b. Kind of Business/Industry<br><b>LUMBER</b>  |   |
| 17. Father's Name (First, Middle, Last)<br><b>THOMAS SYLVESTER SEWELL</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>NORA JACKSON</b>  |                                |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>MARY B. SEWELL</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>611 ELWOOD AVENUE, EASTON, MD 21601</b>   |                                |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>SPRING HILL CEMETERY 12-9</b>  |  | Data  |                                | 20c. Location - City or Town, State<br><b>EASTON, MD</b>   |   |
| 21. Signature of Funeral Service Licensee<br><b>JOHN R. MERCER</b>   |  |   |  | 22. Name and Address of Facility<br><b>FELLOWS, HELFENBEIN &amp; NEWNAM FUNERAL HOME<br/>200 S. HARRISON ST., EASTON, MD</b>  |                                |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Respiratory Failure</b><br>Due to (or as a consequence of):<br><b>b. COPD with Chronic</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |   |                                |  | Approximate Interval Between Onset and Death<br><b>1 year</b><br><br><b>Years</b> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |
|  |  |   |  |   |                                | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |
|  |  |   |  |   |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |                                |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |
| 28d. Describe how injury occurred  |  |   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |                                |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br><b>William H Wood Jr MD</b>  |  | 29c. License number<br><b>1208715</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>12/08/97</b>   |   |
| 30. Name and Address of person who completed cause of death (Item 23a) (Type, Print)<br><b>William H Wood Jr EASTON, MD 21601</b>  |  |   |  |   |                                |  |   |
| 31. Date filed (Month, Day, Year)<br><b>DEC 08 1997</b>  |  | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>  |  |   |                                |  |   |

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39885

|  |   |   |  |   |  |  |  |  |
|--|---|---|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><u>MARIAN Simpson Cox</u>                           |   |  |   | 2. Date of Death<br>Month <u>12</u> Day <u>08</u> Year <u>97</u> |  | 3. Time of Death<br><u>8:15 AM</u>                         |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><u>Snow Hill Nursing Home</u> |   |  |   | 4b. City, Town, or Location of Death<br><u>Snow Hill</u>         |  | 4c. County of Death<br><u>Worcester</u>                    |  |
| Funeral<br>Director  | 5. Social Security Number<br><u>217-10-3800</u>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><u>90</u> Yrs.                 |  | 8. Date of Birth (Month, Day, Year)<br><u>May 29, 1907</u> |  |
|  | 9. Birthplace (State or Foreign Country)<br><u>Maryland</u>                                     |   | 10a. State<br><u>MD</u>  |   | 10b. County<br><u>Wicomico</u>                                   |  | 10c. City, Town or Location<br><u>Salisbury</u>            |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 10e. Street and Number<br><u>720 S. Park Drive</u>  |  | 10f. Zip Code<br><u>21804</u>   |  | 10g. Citizen of What Country?<br><u>U.S.A.</u>   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u>  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>11</u><br>College (1-4 or 5+) _____  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Sales Clerk</u>   |  | 16b. Kind of Business/Industry<br><u>Retail Store</u>   |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><u>Harry F. Adams</u>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Mamie F. Fleming</u>  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>Carolyn Cartwright (Daughter)</u>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>720 S. Park Drive Salisbury, Md. 21804</u>  |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>St. Stephens Cemetery</u>  |  | Date<br><u>Dec 1997</u>   |  | 20c. Location - City or Town, State<br><u>Delmar, Delaware</u>   |  |  |
| 21. Signature of Funeral Service Licensee<br><u>Harry Short-Hannigan</u>   |   |   |  | 22. Name and Address of Facility<br><u>Short Funeral Home</u><br><u>P.O. Box 204 Delmar, De. 19940</u>  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>ESSENTIAL HYPERTENSION</u><br>Due to (or as a consequence of):<br>b. _____<br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |   |  |  |  |  |
| Approximate interval Between Onset and Death<br><u>MANY YEARS</u>  |   |   |  |   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>IDDIM, DEMENTIA, RECENT PNEUMONIA,</u><br><u>UTI WITH SEPSIS, INANITION</u>   |   |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><u>M</u>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |
| 28d. Describe how injury occurred  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |
| 29e. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |  |   |  |  |  |  |
| 29b. Signature and title of certifier<br><u>Southy C. Holzworth M.D.</u>   |   |   |  | 29c. License number<br><u>D 06241</u>   |  | 29d. Date signed (Month, Day, Year)<br><u>12-8-97</u>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>DOROTHY C. HOLZWORTH M.D. 203 SNOW ST. SNOW HILL, MD. 21863</u>   |   |   |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><u>DEC 12 1997</u>  |   |   |  | 32. Registrar's Signature<br><u>John Davidson Randall</u>   |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39886

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Melvina Dorsey

2. Date of Death

Month  
Dec

Day

8

Year

1997

3. Time of Death

6:35P

4a. Facility Name (If not institution, give street and number)

The Memorial Hospital

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

5. Social Security Number

219-07-7345

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 17, 1906

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Talbot

10c. City, Town or Location

Cordova

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13061 Lewistown Rd.

10f. Zip Code

21625

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
6th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Factory

17. Father's Name (First, Middle, Last)

William Johns, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Lottie Young

19a. Informant's Name/Relationship (Type, Print)

Emma Johns (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13061 Lewistown Rd., Cordova, Maryland 21625

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sandtown Cemetery

Date

12/13/97

20c. Location - City or Town, State

Hillsboro, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bennie Smith Funeral Home  
P.O. Box 1687, Easton, Maryland 21601

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Intracerebral hemorrhage

Approximate Interval Between Onset and Death

6 days

Due to (or as a consequence of):

b. Ischemic Cerebral Vascular Accident

8 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acute Myocardial Infarction

Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M. Siuta MD

29c. License number

D44818

29d. Date signed (Month, Day, Year)

12/9/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Siuta MD, 511 Idlewild Ave., Easton, Maryland 21601

31. Date filed (Month, Day, Year)

DEC 11 1997

32. Registrar's Signature

J. Davidson-Randall

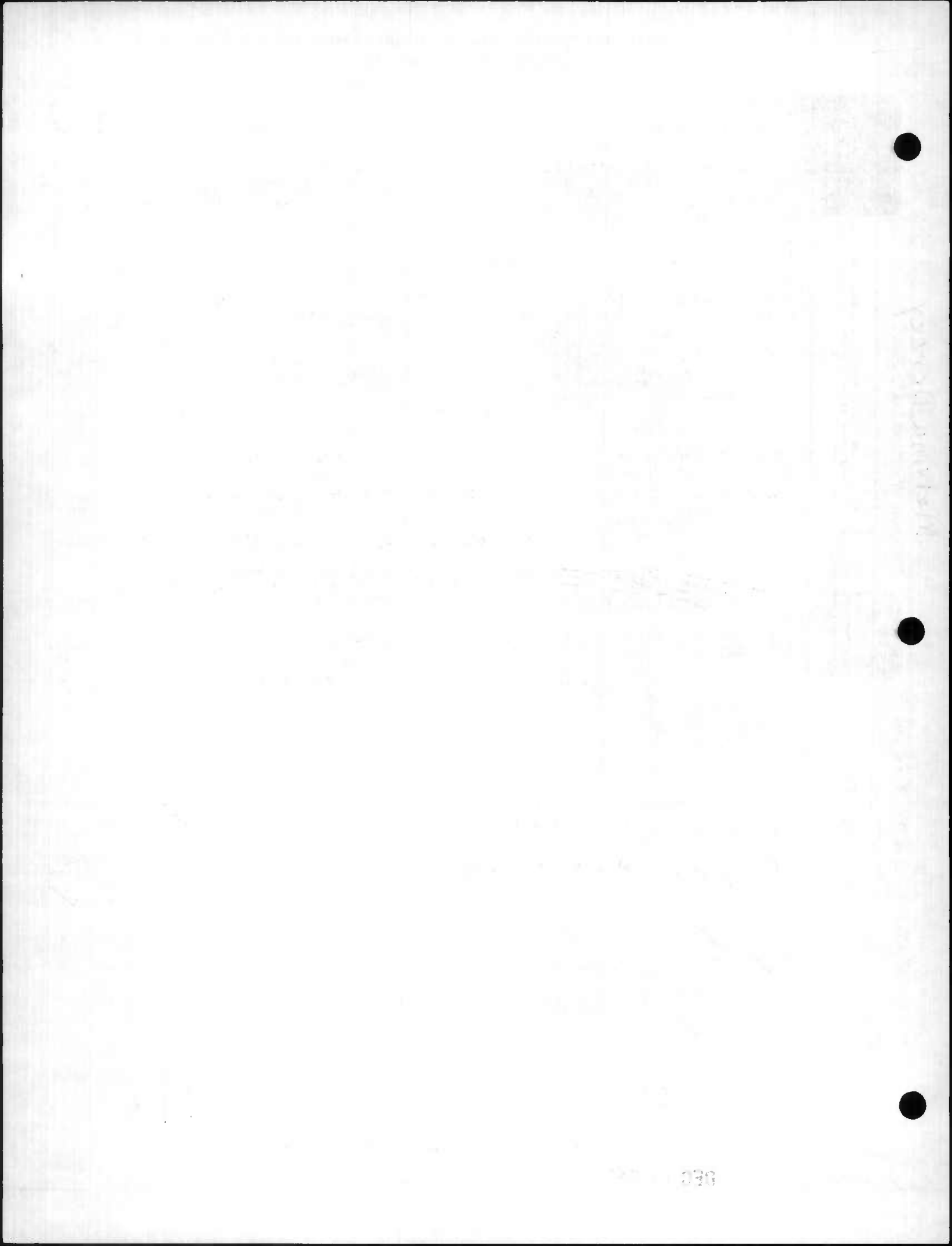
State  
Registrar

Medical Certification: To Be Completed by Physician/Medical Examiner

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 39887

|   |  |                              |   |   |   |  |  |  |   |  |  |
|---|--|------------------------------|---|---|---|--|--|--|---|--|--|
| <b>Physician<br/>/Medical<br/>Examiner</b>  | 1. Decedent's Name (First, Middle, Last)<br><b>WILLIAM ASHTON DUNGAN</b>                   |                              |   |   |   | 2. Date of Death<br>Month <b>DECEMBER</b> Day <b>8</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>7:40am</b>  |   |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>MEMORIAL HOSPITAL</b> |                              |   |   |   | 4b. City, Town, or Location of Death<br><b>EASTON</b>  |  | 4c. County of Death<br><b>TALBOT</b>   |   |  |  |
| <b>Funeral<br/>Director</b>   | 5. Social Security Number<br><b>199-03-3881A</b>   |                              | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 16, 1917</b>                      |  | 9. Birthplace (State or Foreign Country)<br><b>Penna.</b>               |  |  |
|   | Usual Residence of Decedent  |                              |   |   |   |  |  |  |   |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Talbot</b> |   | 10c. City, Town or Location<br><b>St. Michaels</b>  |   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |  |
| 10e. Street and Number<br><b>23987 Mt. Misery Rd.</b>   |  |                              |   | 10f. Zip Code<br><b>21663</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |                              | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>WWII Navy</b><br>If Yes, Give Year or Dates:  |   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> Collage (1-4or 5+) <b>4</b>  |  |                              |   | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>State of Maryland</b> |   |  |  | 16b. Kind of Business/Industry<br><b>Dept. of Employment Security</b>                          |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>J. Evan Dungan</b>  |  |                              |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ethel Lounes Ashton</b>   |  |  |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Lilla P. Dungan Wife</b>   |  |                              |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 767 St. Michaels, Maryland 21663</b> |  |  |  |   |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |                              | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Capitol Crematory Dec. 9, 1997</b>   |   |   | 20c. Location - City or Town, State<br><b>Dover, Delaware</b>  |  |  |   |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Harrison E. Leonard</i>   |  |                              |   |   | 22. Name and Address of Facility<br><b>Harrison E. Leonard Funeral Home<br/>312 S. Talbot St. St. Michaels, Maryland 21663</b>                    |  |  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>pneumonia</b><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><div style="font-size: 4em; margin-left: 100px;">}</div> |  |                              |   |   |   |  |  |  |   | Approximate Interval Between Onset and Death<br><b>Days</b>  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Alzheimer's Dementia C. Diff Diarrhea<br/>Parkinsonism Blood loss Anemia<br/>Gastrointestinal Bleeding Right Hip Fracture<br/>Malnutrition</b>   |  |                              |   |   |   |  |  |  |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |                              |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                              | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |  |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  |                              | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how Injury occurred                                       |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |                              | 29b. Signature and title of certifier<br><i>Michael E. Lees</i>   |   |   | 29c. License number<br><b>D42005</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>12/07/97</b>   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Michael E. Lees M.D. 606 Dutchmans Lane Easton, Maryland 21601</b>   |  |                              |   |   |   |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 09 1997</b>   |  |                              |   |   | 32. Registrar's Signature<br><i>Galia Davidson-Randall</i>  |  |  |  |   |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
Dungan, William  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39888

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOSEPH STANLEY DOYLE

2. Date of Death

Month Day Year  
December 3, 1997

3. Time of Death

4:15 AM

4a. Facility Name (If not institution, give street and number)

Memorial Hospital @ Easton

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral  
Director

5. Social Security Number

204-26-4359

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

65

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

MAR. 19, 1932

9. Birthplace (State or Foreign Country)

PENNSYLVANIA

Usual Residence of Decedent

10a. State

VA

10b. County

FAIRFAX

10c. City, Town or Location

ALEXANDRIA

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

5722 TREMONT DRIVE

10f. Zip Code

22303

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give

Year or Dates: KOREAN

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

MANAGER

16b. Kind of Business/Industry

GOVERNMENT SERVICE

17. Father's Name (First, Middle, Last)

LEO HORACE DOYLE

18. Mother's Name (First, Middle, Maiden Surname)

MARY FLORENCE LYNCH

19a. Informant's Name/Relationship (Type, Print)

NAN MARIE DOYLE/ WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5722 TREMONT DR., ALEXANDRIA, VA 22303

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

MOTHER OF SORROWS

CEMETERY

Date

12-9-97

20c. Location - City or Town, State

FINCH HILL, PA

21. Signature of Funeral Service Licensee

Maurice M. M. M.

22. Name and Address of Facility

FELLOWS, HELFENBEIN &amp; NEWMAN FUNERAL HOME

200 S. HARRISON ST., EASTON, MD 21601

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Acute myocardial infarction

Approximate Interval Between Onset and Death

4 days

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Aspiration pneumonia

Chronic atrial fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Michael S. Smith, MD

29c. License number

D44818

29d. Date signed (Month, Day, Year)

12/3/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael S. Smith, MD

511 Idlewild Ave. Easton MD 21601

State

Registrar

31. Date filed (Month, Day, Year)

DEC 08 1997

32. Registrar's Signature

Julia Davidson-Randall

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Joseph Doyle

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

87 39889

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Samuel Winfield Davis

2. Date of Death  
Month Day Year  
December 5, 19973. Time of Death  
6:38 AM

4a. Facility Name (If not institution, give street and number)

Salisbury Center: Genesis ElderCare

4b. City, Town, or Location of Death

Salisbury, MD

4c. County of Death

Wicomico

Funeral  
Director

5. Social Security Number

215-16-3066

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

SEPT. 12, 09

9. Birthplace (State or Foreign Country)

MARION STA. MD.

Usual Residence of Decedent

10a. State

MD

10b. County

WICOMICO

10c. City, Town or Location

SALISBURY

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

455 PATRICK AVE.,

10f. Zip Code

21801

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LABORER

16b. Kind of Business/Industry

CONSTRUCTION

17. Father's Name (First, Middle, Last)

ALFRED DAVIS

18. Mother's Name (First, Middle, Maiden Surname)

HATTIE ?

19a. Informant's Name/Relationship (Type, Print)

MARILYN BRIDDELL

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7992 DIVIDING CREEK ROAD; POCOMOKE CITY, MD.

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. PEER

Date

12-13

20c. Location - City or Town, State

MARION STATION, MD

21. Signature of Funeral Service Licensee

Loretta B. Jolley

22. Name and Address of Facility

JOLLEY MEMORIAL CHAPEL  
1213 JERSEY ROAD; SALISBURY, MD. 21801

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

One Day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Arterial Fibrosclerosis

Hd CURA

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Loretta B. Jolley

29c. License number

D39813

29d. Date signed (Month) Day, Year

12/5/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

M ATKINS MD

1104 Healthway Dr., Salisbury, MD 21804

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 10 1997

32. Registrar's Signature

John Davidson-Rodell

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

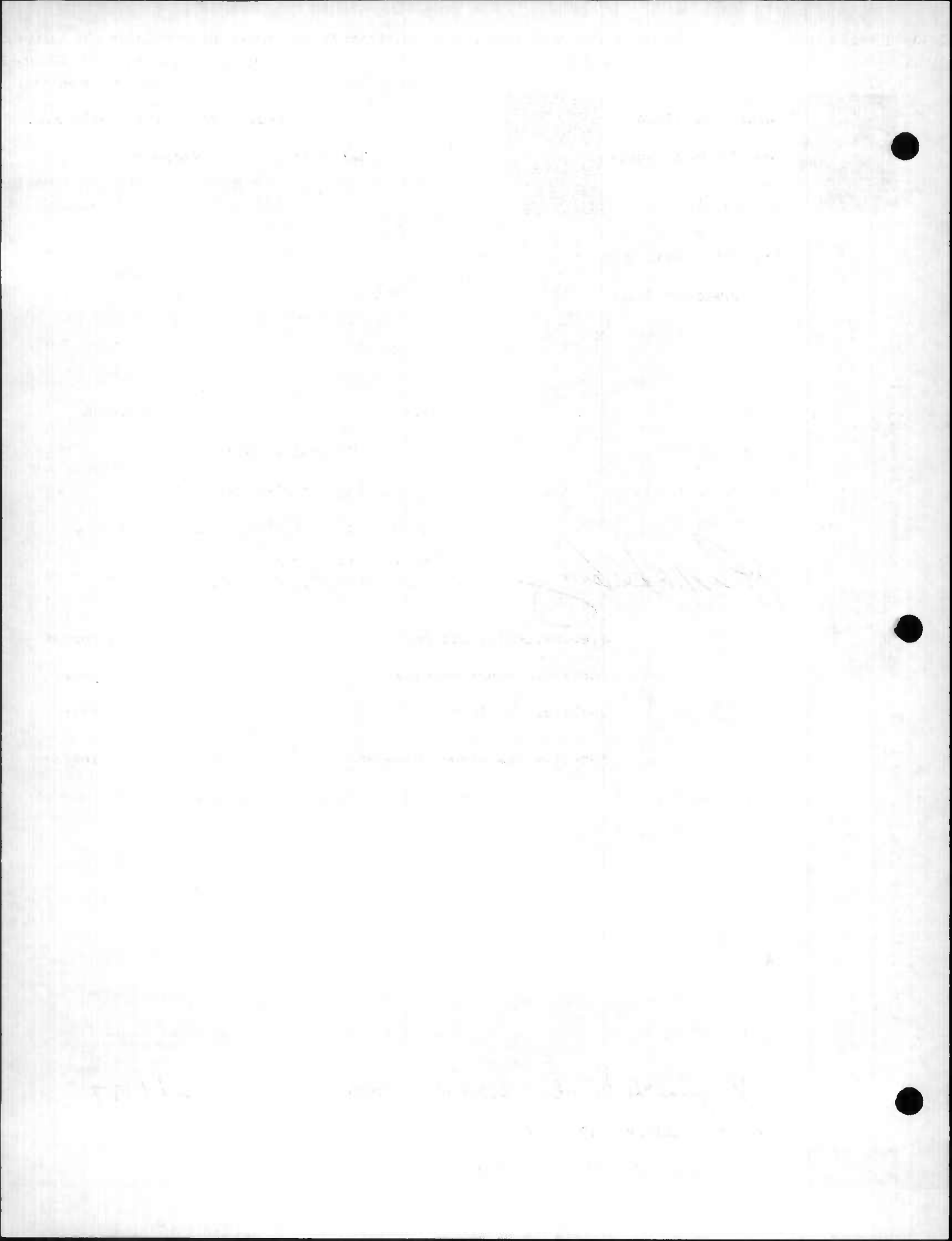
Reg. No.

97 39890

|  |   |  |  |  |  |  |   |  |
|--|---|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Louis Difilippo</b>  |  |  |  | 2. Date of Death<br>Dec. 08 1997   |  | 3. Time of Death<br>3:10 a.m.   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Deer's Head Center</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Salisbury,</b>  |  | 4c. County of Death<br><b>Wicomico</b>                                  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>577-14-1043</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>11/20/20</b>                  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Washington, DC</b>   |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Worcester</b>  |  | 10c. City, Town or Location<br><b>Berlin</b>                            |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent   |  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |
|  | 10e. Street and Number<br><b>9 Sweet Gum Lane</b>   |  |  |  | 10f. Zip Code<br><b>21811</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                             |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW II</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>6</b>   |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>C.I.A.</b>   |  | 16b. Kind of Business/Industry<br><b>U.S. Government</b>                |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Abramo Di Filippo</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Giacomina Spinelli</b>   |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Marion M. Di Filippo/ Wife</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8075 Ocean Pines, Berlin, MD 21811</b>   |  |   |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Salisbury Crematory</b>   |  | Date<br><b>12/10/97</b>  |  | 20c. Location - City or Town, State<br><b>Salisbury, MD</b>             |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  |  |  | 22. Name and Address of Facility<br><b>Holloway Funeral Home<br/>501 Snow Hill Rd., Salisbury, MD 21804</b>  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Cerebrovascular accident</b>  |  |  |  |  |  |   |  |
|  | 23b. Approximate Interval Between Onset and Death<br><b>3 months</b>  |  |  |  |  |  |   |  |
| Physician<br>/Medical<br>Examiner  | 23c. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>End stage renal disease</b>  |  |  |  |  |  |   |  |
|  | 23d. Due to (or as a consequence of):<br><b>2 years</b>   |  |  |  |  |  |   |  |
|  | 23e. Due to (or as a consequence of):<br><b>Nephrectomy, left</b>   |  |  |  |  |  |   |  |
|  | 23f. Due to (or as a consequence of):<br><b>2 years</b>   |  |  |  |  |  |   |  |
|  | 23g. Due to (or as a consequence of):<br><b>Recurrent carcinoma bladder</b>   |  |  |  |  |  |   |  |
|  | 23h. Due to (or as a consequence of):<br><b>years</b>   |  |  |  |  |  |   |  |
|  | 23i. Due to (or as a consequence of):<br><b>years</b>   |  |  |  |  |  |   |  |
|  | 23j. Due to (or as a consequence of):<br><b>years</b>   |  |  |  |  |  |   |  |
|  | 23k. Due to (or as a consequence of):<br><b>years</b>   |  |  |  |  |  |   |  |
|  | 23l. Due to (or as a consequence of):<br><b>years</b>   |  |  |  |  |  |   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |  |  |  |   |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |  |  |   |  |
|  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |  |  |   |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |  |  |   |  |
|  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |   |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                     |  |  |  |  |  |   |  |
|  | 28a. Date of Injury (Month, Day Year)<br><b>12/10/97</b>  |  |  |  |  |  |   |  |
|  | 28b. Time of Injury<br><b>M</b>   |  |  |  |  |  |   |  |
|  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |  |  |   |  |
| 28d. Describe how injury occurred  |   |  |  |  |  |  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |  |  |  |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |  |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |  |  |  |  |   |  |
| 29b. Signature and title of certifier<br>  |   |  |  |  |  |  |   |  |
| 29c. License number<br><b>D33905</b>   |   |  |  |  |  |  |   |  |
| 29d. Date signed (Month, Day, Year)<br><b>12/9/97</b>  |   |  |  |  |  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Virginia A. Dulany, M.D., CMD</b>   |   |  |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 10 1997</b>  |   |  |  |  |  |  |   |  |
| 32. Registrar's Signature<br>  |   |  |  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39891

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SELINA MAE FAIRBANK

2. Date of Death

Month Day Year  
DEC. 4, 1997

3. Time of Death

10.00 A.M.

4a. Facility Name (If not institution, give street and number)

Genesis Elder Care the Pines

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral  
Director

5. Social Security Number

214-38-7082

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

100

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 14, 1897

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Talbot

10c. City, Town or Location

St. Michaels

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

412 Water St.

10f. Zip Code

21663

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry  
Extension Office  
Maryland State

17. Father's Name (First, Middle, Last)

Walter W. Fairbank

18. Mother's Name (First, Middle, Maiden Surname)

Ella Jewell

19a. Informant's Name/Relationship (Type, Print)

Rachel F. Marsh Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

607 Cove Rd. St. Michaels, Maryland 21663

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Olivet Cemetery Dec. 8, 1997

Date

20c. Location - City or Town, State

St. Michaels, Maryland

21. Signature of Funeral Service Licensee

Harrison E. Leonard

22. Name and Address of Facility

Harrison E. Leonard Funeral Home  
312 S. Talbot St. St. Michaels, Maryland 21663

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. CORONARY ARTERY DISEASE  
Due to (or as a consequence of):

Approximate interval between Onset and Death

YEARS

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

IRON DEFICIENCY ANEMIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William S. Bremer

29c. License number

D26350

29d. Date signed (Month, Day, Year)

12/5/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

William S. Bremer M.D. 800 S. Talbot St. St. Michaels, Maryland 21663

31. Date filed (Month, Day, Year)

DEC 09 1997

32. Registrar's Signature

Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

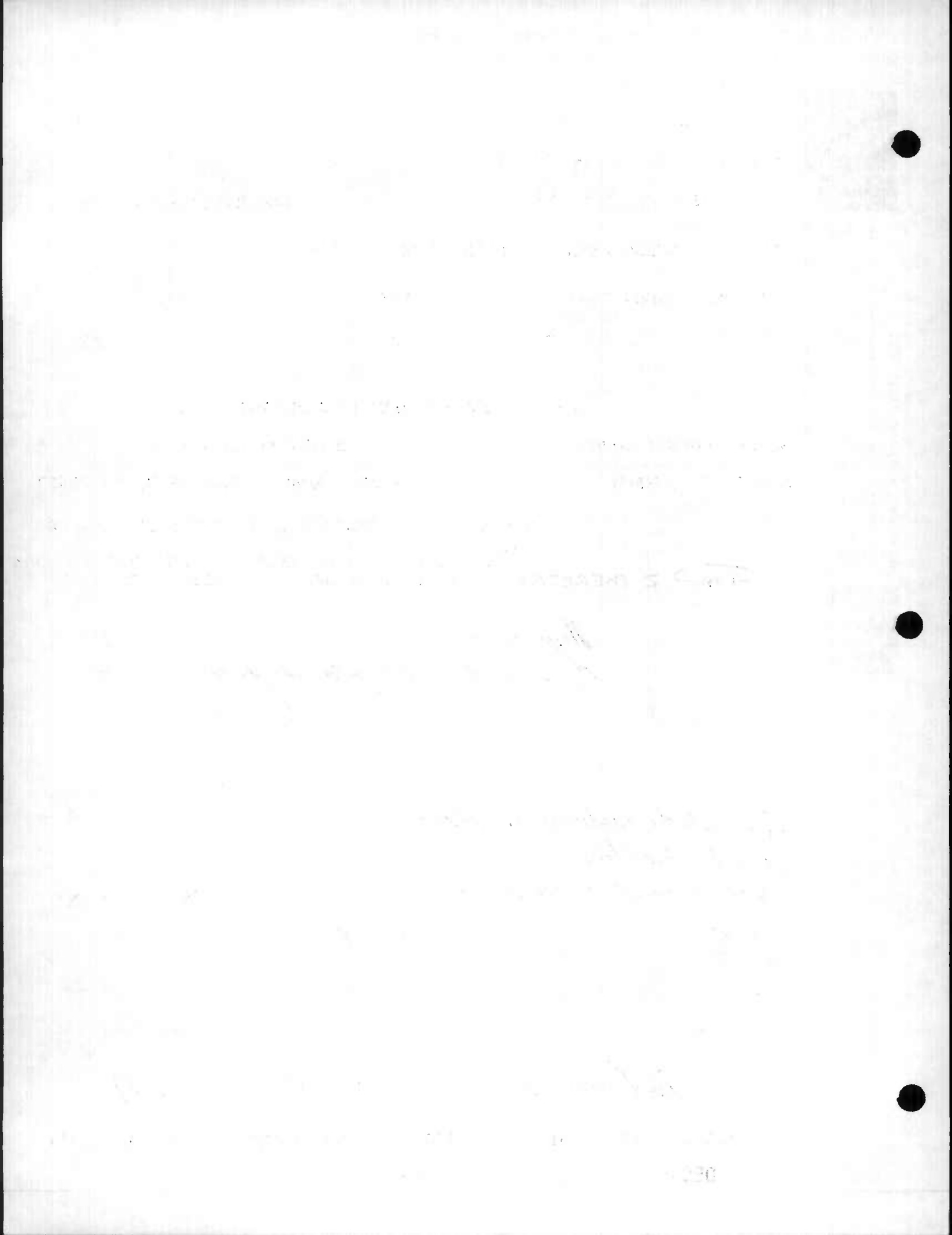
Reg. No.

97 39892

|   |   |   |   |  |  |  |  |   |  |
|---|---|---|---|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Edith ANN Gordon</b>   |   |   |  | 2. Date of Death<br>Month <b>Dec</b> Day <b>4</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>9:15 PM</b>   |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Genesis ElderCare - The Pines</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>Easton</b>  |  | 4c. County of Death<br><b>Talbot</b>   |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-60-9130</b>   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>AUG. 21, 1914</b>  | 9. Birthplace (State or Foreign Country)<br><b>NEW JERSEY</b> |  |
|   | Usual Residence of Decedent   |   |   |  |  |  |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>   |   | 10b. County<br><b>QUEEN ANNE</b>  |  | 10c. City, Town or Location<br><b>QUEEN ANNE</b>   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |  |
|   | 10e. Street and Number<br><b>813 FOX MEADOW ROAD</b>  |   |   |  | 10f. Zip Code<br><b>21657</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |
|   | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                            |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>-0-</b>  |   | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>NEVER WORKED-HANDICAPPED</b>           |  | 16b. Kind of Business/Industry<br><b>N/A</b>   |  |  |   |  |
| To Be Completed by Physician/Medical Examiner   | 17. Father's Name (First, Middle, Last)<br><b>SAMUEL ROBERT GORDON</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARGARET ELLA WOOD</b>   |  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>MONICA C. SEWARD</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>813 FOX MEADOW ROAD, QUEEN ANNE, MD 21657</b>  |  |  |   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>STEVENSVILLE CEMETERY</b>  |  | Data<br><b>12-9</b>  |  | 20c. Location - City or Town, State<br><b>STEVENSVILLE, MD</b>                                     |   |  |
|   | 21. Signature of Funeral Service Licensee<br><b>John R. Mercer</b>  |   | 22. Name and Address of Facility<br><b>FELLOWS, HELFENBEIN &amp; NEWNAM FUNERAL HOME<br/>200 S. HARRISON ST., EASTON, MD 21601</b>                    |  |  |  |  |   |  |
| Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                       |   |   |  |  |  |  |   |  |
|   | Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Hypoxemia</b><br>Due to (or as a consequence of):  |   |   |  |  |  |  |   |  |
|   | b. <b>Chronic obstructive pulmonary disease</b><br>Due to (or as a consequence of):   |   |   |  |  |  |  |   |  |
|   | c. <b>Severe peripheral vascular disease</b><br>Due to (or as a consequence of):  |   |   |  |  |  |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause (Disease or injury that initiated events resulting in death) Last<br>d.  |   |   |   |  |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Atherosclerotic cardiovascular disease</b><br><b>Congestive heart failure</b><br><b>Severe peripheral vascular disease</b>   |   |   |   |  |  |  |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |   |   |   |  |  |  |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |   |  |  |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |   |  |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>                  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred                             |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><b>Michael D. Crowley, Jr.</b>   |   |  |  |  |  |   |  |
| 29c. License number<br><b>D25933</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>12.5.97</b>   |   |  |  |  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>MICHAEL D. CROWLEY, JR., M.D., 508 IDLEWILD AVENUE, EASTON, MD 21601</b>   |   |   |   |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 08 1997</b>   |   | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>  |   |  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39893

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy E. George

2. Date of Death

Month Day Year

12 11 97

3. Time of Death

9:28 pm

4a. Facility Name (If not institution, give street and number)

FHCC 30 North Place

4b. City, Town, or Location of Death

FREDERICK MD

4c. County of Death

FREDERICK

5. Social Security Number

5-77-09-8566

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

6/26/17

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

DELAWARE

10b. County

SUSSEX

10c. City, Town or Location

MILLSBORO

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1002 BRANDYWINE III

10f. Zip Code

19966

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

EDWIN HENLEY

18. Mother's Name (First, Middle, Maiden Surname)

BEATRICE MCCROSSIN

19a. Informant's Name/Relationship (Type, Print)

HEATHER L. HENLEY/NIECE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

211 CRABB AVE., ROCKVILLE, MARYLAND 20850

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ST. GEORGE'S CEMETERY

Date

12/15/97

20c. Location - City or Town, State

CLARKSVILLE, DELAWARE

21. Signature of Funeral Service Licensee

*Charles W. Hastings*

22. Name and Address of Facility

HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 19975

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Dementia

Approximate Interval Between Onset and Death

years

b.

Alzheimer's Disease

years

c.

d.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dehydration

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Medical Examiner

2 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*William H. Johnson*

29c. License number

D47556

29d. Date signed (Month, Day, Year)

12/11/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILLIAM H. JOHNSON AND 187 THOMAS JOHNSON DRIVE, FREDERICK, MD

31. Date filed (Month, Day, Year)

DEC 15 1997

32. Registrar's Signature

*Julia Davidson*

21702

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39894

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Carrie Mae Gregory

2. Date of Death

Month Day Year  
12 10 97

3. Time of Death

1934

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

244-34-5346

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 6, 1929

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10e. State

MD

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

405 Bueclar Drive

10f. Zip Code

21801

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

n/a

16b. Kind of Business/Industry

n/a

17. Father's Name (First, Middle, Last)

John Frank Leak, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Candies Martin

19a. Informant's Name/Relationship (Type, Print)

Terrie M. Jones/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

530 Hammond St., Salisbury, MD 21804

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Acres Mem Park

Date

12/13/97

20c. Location - City or Town, State

Salisbury, MD

21. Signature of Funeral Service Licenses

22. Name and Address of Facility

Lewis N. Watson Funeral Home  
1618 West Rd., Salisbury, MD 21801

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Intracerebral Hemorrhagic stroke

Due to (or as a consequence of):

Approximate interval between Onset and Death

1d

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Acquired Coagulopathy

Due to (or as a consequence of):

2d

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

UGI Bleed

Lx CVA

Lx P.E.

Lx DVT

Lx Adenoc (R) lung

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D47619

29d. Date signed (Month, Day, Year)

12/11/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Oscar Gualteros 262 Tilghman Rd Salisbury MD 21804

31. Date filed (Month, Day, Year)

DEC 12 1997

32. Registrar's Signature

Jahia Anderson-Randall

State Registrar

Carrie Gregory

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

12



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39895

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

AMY

WOODROW

GORDY

2. Date of Death

Month

Day

Year

DECEMBER 8, 1997

3. Time of Death

1449 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

214-10-6486

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

4/20/13

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1011 Heron Court

10f. Zip Code

21804

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Owner

16b. Kind of Business/Industry

Shoe Store

17. Father's Name (First, Middle, Last)

William G. Shockley

18. Mother's Name (First, Middle, Maiden Surname)

Minnie Hammond

19a. Informant's Name/Relationship (Type, Print)

Phyllis Kay Phillips/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5393 Royal Mile Blvd. Salisbury, MD 21801

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Parsons Cemetery

Date

12/12/97

20c. Location - City or Town, State

Salisbury, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Holloway Funeral Home

501 Snow Hill Rd., Salisbury, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a.

Coronary Artery Disease - Myocardial Rupture

Due to (or as a consequence of):

b.

Acute Myocardial Infarction

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

M

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29e. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D40715

29d. Date signed (Month, Day, Year)

12/12/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Steven Hearne, MD 400 Eastern Shore Dr. Salisbury, Md. 21804

31. Date filed (Month, Day, Year)

DEC 12 1997

32. Registrar's Signature

Julia Anderson-Randall

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39896

|  |  |  |   |  |   |   |   |  |   |   |  |    |    |    |
|--|--|--|---|--|---|---|---|--|---|---|--|----|----|----|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Percy Linwood Harrison</b>                              |  |   |  | 2. Date of Death<br>Month <b>Dec</b> Day <b>10</b> Year <b>1997</b> |   | 3. Time of Death<br><b>6:19PM</b>                           |  |   |   |  |    |    |    |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Genesis ElderCare - The Pines</b> |  |   |  | 4b. City, Town, or Location of Death<br><b>Easton</b>               |   | 4c. County of Death<br><b>Talbot</b>                        |  |   |   |  |    |    |    |
| Funeral<br>Director  | 5. Social Security Number<br><b>213-09-8453</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>89</b> Yrs.                    |   | 8. Date of Birth (Month, Day, Year)<br><b>NOV. 21, 1908</b> |  |   |   |  |    |    |    |
|  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>TALBOT</b>  |   | 10c. City, Town or Location<br><b>EASTON</b>                |  |   |   |  |    |    |    |
| Usual Residence of Decedent  |  |  |   |  |   |   |   |  |   |   |  |    |    |    |
| 10a. Street and Number<br><b>29425 HAWKES HILL ROAD</b>  |  |  | 10f. Zip Code<br><b>21601</b>   |  |   | 10g. Citizen of What Country?<br><b>USA</b>   |   |  |   |   |  |    |    |    |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  |   |   |  |    |    |    |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>1</b>             |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>OWNER/OPERATOR</b>  |   |  |   |   |  |    |    |    |
| 16b. Kind of Business/Industry<br><b>FREIGHT</b>   |  |  | 17. Father's Name (First, Middle, Last)<br><b>PERCY WILLIAM HARRISON</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ESTA MAY</b>  |   |  |   |   |  |    |    |    |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>HELEN N. HARRISON/ WIFE</b>   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>29425 HAWKES HILL RD., EASTON, MD 21601</b>   |  |   |   |   |  |   |   |  |    |    |    |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>SHERWOOD CEMETERY</b>  |  |   | 20c. Location - City or Town, State<br><b>12-13 SHERWOOD, MD</b>  |   |  |   |   |  |    |    |    |
| 21. Signature of Funeral Service Licensee<br><b>M. E. Newnam III CFSP</b>  |  |  | 22. Name and Address of Facility<br><b>FELLOWS, HELFENBEIN &amp; NEWNAM FUNERAL HOME<br/>200 S. HARRISON ST., EASTON, MD 21601</b>                |  |   |   |   |  |   |   |  |    |    |    |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |   |  |   |   |   |  |   |   |  |    |    |    |
| <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a. <u>Multiple subcortical cerebral infarctions</u> Uncertain</td> <td rowspan="4">           Due to (or as a consequence of):<br/><br/>           Due to (or as a consequence of):<br/><br/>           Due to (or as a consequence of):<br/><br/>           Due to (or as a consequence of):         </td> </tr> <tr><td>b. </td></tr> <tr><td>c. </td></tr> <tr><td>d. </td></tr> </table> |  |  |   |  |   |   |   |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <u>Multiple subcortical cerebral infarctions</u> Uncertain | Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): | b. | c. | d. |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | a. <u>Multiple subcortical cerebral infarctions</u> Uncertain  | Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |   |  |   |   |   |  |   |   |  |    |    |    |
|  | b.   |  |   |  |   |   |   |  |   |   |  |    |    |    |
|  | c.   |  |   |  |   |   |   |  |   |   |  |    |    |    |
|  | d.   |  |   |  |   |   |   |  |   |   |  |    |    |    |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>None</u>  |  |  |   |  |   |   |   |  |   |   |  |    |    |    |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |   |  |   |   |   |  |   |   |  |    |    |    |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  |   |   |   |  |   |   |  |    |    |    |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |   |  |   |   |   |  |   |   |  |    |    |    |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  |   |   |   |  |   |   |  |    |    |    |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |   |  |   |   |   |  |   |   |  |    |    |    |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  |  |   |  |   |   |   |  |   |   |  |    |    |    |
| 28a. Date of Injury (Month, Day, Year)<br>28b. Time of Injury<br>28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>28d. Describe how injury occurred<br>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |  |   |   |   |  |   |   |  |    |    |    |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |  |   |  |   |   |   |  |   |   |  |    |    |    |
| 29b. Signature and title of certifier<br><u>Robert W. Trever, M.D.</u>   |  |  |   |  |   |   |   |  |   |   |  |    |    |    |
| 29c. License number<br><u>D10938</u>   |  |  |   |  |   |   |   |  |   |   |  |    |    |    |
| 29d. Date signed (Month, Day, Year)<br><u>12-11-97</u>   |  |  |   |  |   |   |   |  |   |   |  |    |    |    |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><u>ROBERT TREVER, MD 7696 OCEAN GATEWAY EASTON, MD 21601</u>   |  |  |   |  |   |   |   |  |   |   |  |    |    |    |
| 31. Date filed (Month, Day, Year)<br><b>DEC 12 1997</b>  |  |  |   |  |   |   |   |  |   |   |  |    |    |    |
| 32. Registrar's Signature<br><u>Lisa Davidson-Randall</u>  |  |  |   |  |   |   |   |  |   |   |  |    |    |    |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

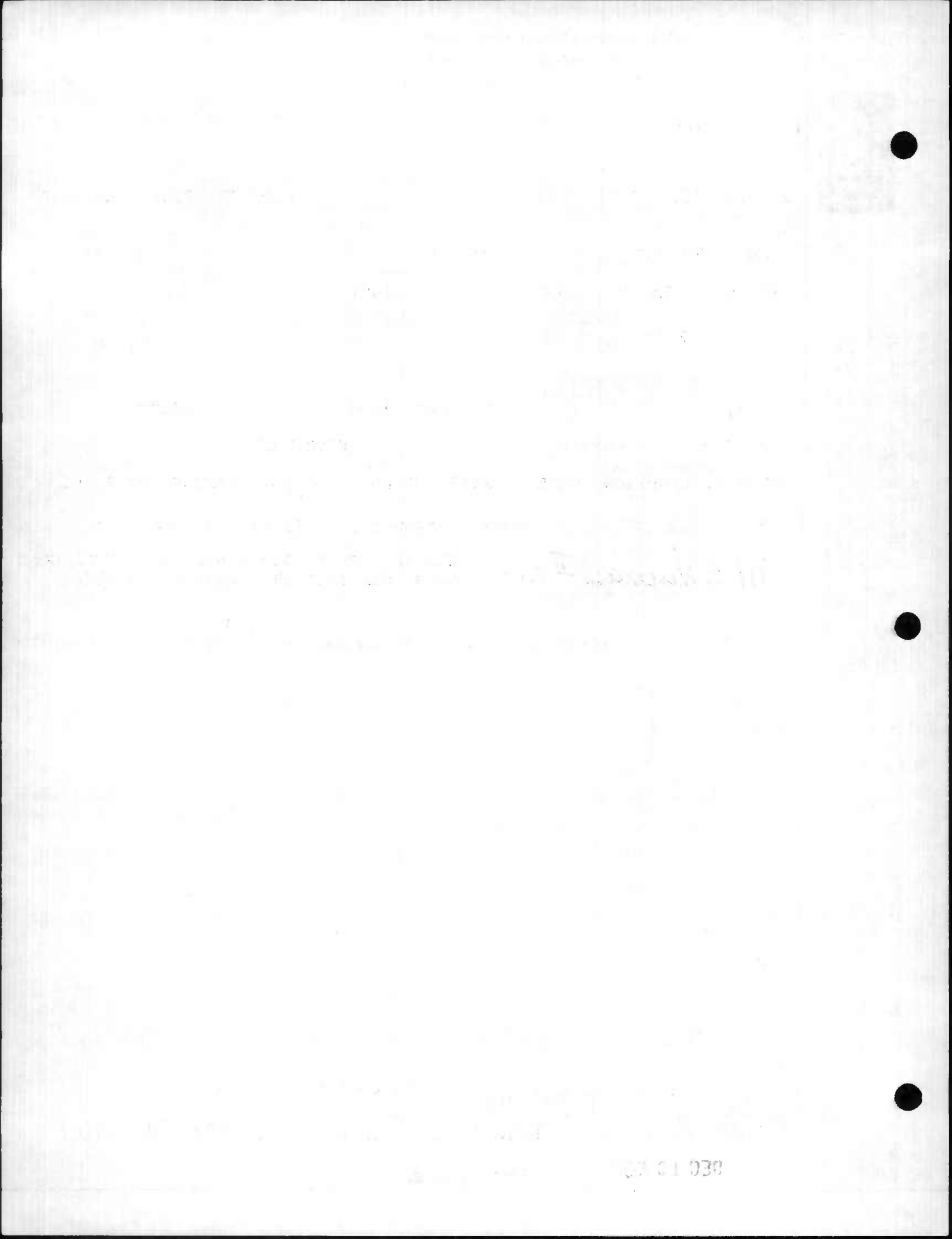
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



030 01 030

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39897

|   |   |  |  |  |   |  |   |  |
|---|---|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Edward Tilghman Johns                             |  |  |  | 2. Date of Death<br>Month Day Year<br>Dec. 11, 1997 |  | 3. Time of Death<br>04:15AM                         |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Memorial Hospital at Easton |  |  |  | 4b. City, Town, or Location of Death<br>Easton      |  | 4c. County of Death<br>Talbot                       |  |
| Funeral<br>Director   | 5. Social Security Number<br>215-26-4650  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>73 Yrs.           |  | 8. Date of Birth (Month, Day, Year)<br>Nov. 4, 1924 |  |
|   | 9. Birthplace (State or Foreign Country)<br>Maryland  |  | 10a. State<br>Maryland   |  | 10b. County<br>Talbot                               |  | 10c. City, Town or Location<br>Trappe               |  |
| Usual Residence of Decedent   |   |  |  |  |   |  |   |  |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |  |  |   |  |   |  |
| 10e. Street and Number<br>29577   |   |  |  |  |   |  |   |  |
| 10f. Zip Code<br>21673  |   |  |  |  |   |  |   |  |
| 10g. Citizen of What Country?<br>USA  |   |  |  |  |   |  |   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   |  |  |  |   |  |   |  |
| 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   |  |  |  |   |  |   |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |   |  |  |  |   |  |   |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: Black  |   |  |  |  |   |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8th College (1-4 or 5+)  |   |  |  |  |   |  |   |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Laborer  |   |  |  |  |   |  |   |  |
| 16b. Kind of Business/Industry<br>Cold Water  |   |  |  |  |   |  |   |  |
| 17. Father's Name (First, Middle, Last)<br>Thomas Edward Johns  |   |  |  |  |   |  |   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary Ella Brooks   |   |  |  |  |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Eugenia Johns Wife  |   |  |  |  |   |  |   |  |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>29577 Backtown Rd., Trappe, Maryland 21673   |   |  |  |  |   |  |   |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |  |  |  |   |  |   |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Capital Crematory   |   |  |  |  |   |  |   |  |
| 20c. Location - City or Town, State<br>12/12/97 Dover, Delaware   |   |  |  |  |   |  |   |  |
| 21. Signature of Funeral Service Licensee<br>John H. Prince   |   |  |  |  |   |  |   |  |
| 22. Name and Address of Facility<br>Bennie Smith Funeral Home<br>P.O. Box 1687, Easton, Maryland 21601  |   |  |  |  |   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Ischemic Heart Disease<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |   |  |  |  |   |  |   |  |
| Approximate Interval Between Onset and Death<br>Yrs   |   |  |  |  |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Diabetes<br>DVT/PE<br>CVA   |   |  |  |  |   |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |  |  |  |   |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |  |  |   |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |  |  |   |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |  |  |   |  |   |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |   |  |  |  |   |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   |  |  |  |   |  |   |  |
| 28a. Date of Injury (Month, Day, Year)  |   |  |  |  |   |  |   |  |
| 28b. Time of Injury<br>M  |   |  |  |  |   |  |   |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |  |  |   |  |   |  |
| 28d. Describe how injury occurred   |   |  |  |  |   |  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  |  |   |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |   |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |  |  |  |   |  |   |  |
| 29b. Signature and title of certifier<br>[Signature]  |   |  |  |  |   |  |   |  |
| 29c. License number<br>D44749   |   |  |  |  |   |  |   |  |
| 29d. Date signed (Month, Day, Year)<br>12, 11, 97   |   |  |  |  |   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Whitesell, Peter MD, 508 Idlewild Ave. Easton, Maryland 21601   |   |  |  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br>DEC 12 1997  |   |  |  |  |   |  |   |  |
| 32. Registrar's Signature<br>Julia Davidson Randall   |   |  |  |  |   |  |   |  |

Johns, Edward

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 5053.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 39898

|   |  |  |  |   |  |   |  |   |
|---|--|--|--|---|--|---|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ELSIE MARSHALL JONES</b>  |  |  |   | 2. Date of Death<br>Month Day Year<br><b>November 30, 1997</b>   |   | 3. Time of Death<br><b>7:30 A.</b>   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>101 East Chew Ave.</b>  |  |  |   | 4b. City, Town, or Location of Death<br><b>St. Michaels</b>  |   | 4c. County of Death<br><b>Talbot</b>   |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>217-07-0887</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                        | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 17, 1916</b>   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
|   | Usual Residence of Decedent  |  |  |   | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Talbot</b>   |   |
| To Be Completed by Funeral Director   | 10c. City, Town or Location<br><b>St. Michaels</b>   |  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 10e. Street and Number<br><b>101 E. Chew Ave.</b>  |   |
|   | 10f. Zip Code<br><b>21663</b>  |  |  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |   |
|   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  |  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+)   |  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>  |   | 16b. Kind of Business/Industry<br><b>Home</b>  |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>William Raymond Marshall</b>   |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Florence Tarbutton</b>   |   |  |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Carl R. Jones Son</b>   |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2 Sumner Ct. Fredericksburg, Virginia 22407</b>  |   |  |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Olivet Cemetery Dec. 3, 1997</b>  |   | 20c. Location - City or Town, State<br><b>St. Michaels, Maryland</b>   |   |
|   | 21. Signature of Funeral Service Licensee<br><i>Harrison E. Leonard</i>  |  |  |   | 22. Name and Address of Facility<br><b>Harrison E. Leonard Funeral Home<br/>312 S. Talbot St. St. Michaels, Maryland 21663</b>   |   |  |   |
|   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Cardiac arrest 2°</b> minutes<br>Due to (or as a consequence of):<br>b. <b>Diabetes mellitus, known</b> years<br>Due to (or as a consequence of):<br>c. <b>Coronary artery disease</b> years<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |   |  |   |  |   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>hypothyroidism</b>  |  |  |   |  |   |  |   |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |  |   |  |   |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |   |  |   |  |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |   |  |   |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M                              |  |   |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 28d. Describe how injury occurred   |  |   |  |   |
| 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |  |   |  |   |  |   |
| 29b. Signature and title of certifier<br><i>Michelle Ong</i>  |  |  |  | 29c. License number<br><b>D45125</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>12/3/97</b> |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Michelle Ong M.D. 606 Dutchmans Lane Easton, Maryland 21601</b>  |  |  |  |   |  |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>DEC 09 1997</b>   |  |  |  | 32. Registrar's Signature<br><i>Lelia Davidson-Randall</i>  |  |   |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39899

|  |   |  |  |  |  |  |   |  |
|--|---|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>THOMAS WENDELL KURTINECZ</b>   |  |  |  | 2. Date of Death<br>Month Day Year<br><b>NOV. 26, 1997</b>   |  | 3. Time of Death<br><b>1919 PM</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>PENINSULA REGIONAL HOSPITAL CENTER</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>SALISBURY</b>   |  | 4c. County of Death<br><b>WICOMICO</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>220-46-5944</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>43</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 16, 1954</b>   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Dorchester</b>   |  | 10c. City, Town or Location<br><b>Federalsburg</b>  |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 10e. Street and Number<br><b>6479 Wheatley Rd.</b>   |  | 10f. Zip Code<br><b>21632</b>   |  |
|  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
|  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+)                      |  |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Truck Driver</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>Lyons Trucking</b>  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Nich Kurtinecz</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Sumama)<br><b>Stella Drobisz</b>  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Donna Turnbull Kurtinecz Wife</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6479 Wheatley Rd. Federalsburg, Maryland 21632</b>   |  |   |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Capitol Crematory Nov. 28, 1997 Dover, Delaware</b>   |  |   |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Harrison E. Leonard</i>   |  |  |  | 22. Name and Address of Facility<br><b>Harrison E. Leonard Funeral Home<br/>312 S. Talbot St. St. Michaels, Maryland 21663</b>   |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Multiple Injuries</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |  |  | Approximate Interval Between Onset and Death   |  |   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |  | 28. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |   |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide |   |  |  | 28a. Date of Injury (Month, Day, Year)<br><b>11-26-97</b>  |  |  |   |  |
| 28b. Time of Injury<br><b>18 20 M</b>  |   |  |  | 28c. Injury at Work?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |   |  |
| 28d. Describe how injury occurred<br><b>pedestrian struck by Auto.</b>   |   |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Roadway</b>   |  |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>US 50</b>   |   |  |  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |  |
| 29b. Signature and title of Certifier<br><i>[Signature]</i>  |   |  |  | 29c. License number<br><b>O.C.M.E</b>  |  |  |   |  |
| 29d. Date signed (Month, Day, Year)<br><b>NOV. 27, 1997</b>  |   |  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 09 1997</b>  |   |  |  | 32. Registrar's Signature<br><i>[Signature]</i>  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

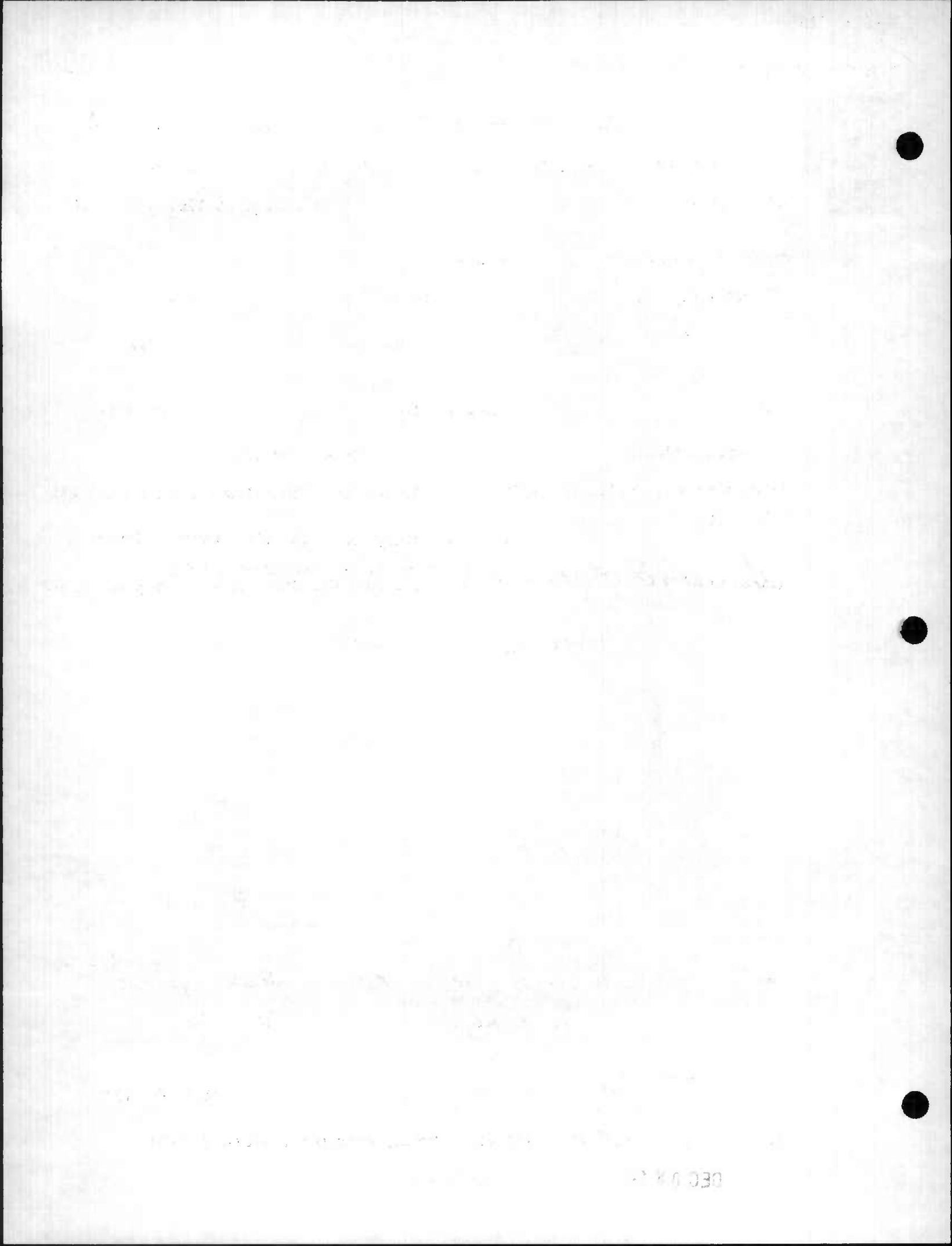
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39900

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

MARY LOUISE LEDFORD

2. Date of Death

Month Day Year  
Dec. 4, 1997

3. Time of Death

7:30 A.M.

4a. Facility Name (If not institution, give street and number)

9684 Leeds Landing Circle

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

5. Social Security Number

578-16-4431

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 18, 1921

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Talbot

10c. City, Town or Location

Easton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9684 Leeds Landing Circle

10f. Zip Code

21601

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Forna R. Weinrich

18. Mother's Name (First, Middle, Maiden Summa)

Mary Louella Grady

19a. Informant's Name/Relationship (Type, Print)

Stanley B. Ledford Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9684 Leeds Landing Circle Easton, Maryland 21601

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dec. 10, 1997  
Arlington National Cemetery

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Harrison E. Leonard Funeral Home  
312 S. Talbot St. St. Michaels, Maryland 21663

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Endometrial Cancer

Due to (or as a consequence of):

Approximate interval Between Onset and Death

3 mo

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 01225

29d. Date signed (Month, Day, Year)

12-8-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen P. Carney M.D. 509 Idlewild Ave. Easton, Maryland 21601

31. Date filed (Month, Day, Year)

DEC 09 1997

32. Registrar's Signature

State  
RegistrarBaltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

100-100





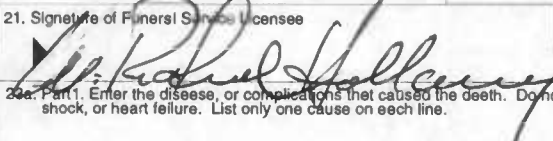
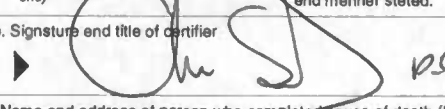
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39902

|  |  |  |                                 |   |   |   |   |   |
|--|--|--|---------------------------------|---|---|---|---|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><u>Avery J. Lewis</u>  |  |                                 |   | 2. Date of Death<br>Month <u>December</u> Day <u>7</u> Year <u>1997</u> |   | 3. Time of Death<br><u>1330</u>   |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><u>PENINSULA REGIONAL MEDICAL CENTER</u> |  |                                 |   | 4b. City, Town, or Location of Death<br><u>SALISBURY</u>                |   | 4c. County of Death<br><u>WICOMICO</u>                                  |   |
| Funeral<br>Director  | 5. Social Security Number<br><u>217-42-5175</u>  |  | 6. Sex<br><u>1</u> M <u>2</u> F | 7. Age (In yrs. last birthday)<br><u>54</u> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                              | 8. Date of Birth (Month, Day, Year)<br><u>8/21/43</u>                   | 9. Birthplace (State or Foreign Country)<br><u>Maryland</u>   |
|  | Usual Residence of Decedent  |  |                                 |   |   |   |   |   |
| 10a. State<br><u>Maryland</u>  |  | 10b. County<br><u>Wicomico</u>   |                                 | 10c. City, Town or Location<br><u>Salisbury</u>   |   |   | 10d. Inside City Limits<br><u>1</u> Yes <u>2</u> No                     |   |
| 10e. Street and Number<br><u>7882 Dublin Road</u>  |  |  |                                 | 10f. Zip Code<br><u>21801</u>   |   | 10g. Citizen of What Country?<br><u>USA</u>                 |   |   |
| 11. Marital Status<br><u>1</u> Never Married <u>2</u> Married<br><u>3</u> Widowed <u>4</u> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><u>1</u> Yes <u>2</u> No<br>If Yes, Give Year or Dates: <u>Navy</u>   |                                 | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><u>1</u> Yes <u>2</u> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u> |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>3</u>  |  |  |                                 | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>L.P.N.</u>                        |   |   | 16b. Kind of Business/Industry<br><u>Nursing</u>                        |   |
| 17. Father's Name (First, Middle, Last)<br><u>Leroy Lewis</u>  |  |  |                                 | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Lillian Edna Shockley</u>   |   |   |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>Linda M. Lewis/Wife</u>   |  |  |                                 | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>7882 Dublin Rd., Salisbury, MD 21801</u>      |   |   |   |   |
| 20a. Method of Disposition<br><u>1</u> Burial <u>2</u> <input checked="" type="checkbox"/> Cremation <u>3</u> Removal from State<br><u>4</u> Donation <u>5</u> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Salisbury Crematory</u>   |                                 | Date<br><u>12/9/97</u>  |   | 20c. Location - City or Town, State<br><u>Salisbury, MD</u> |   |   |
| 21. Signature of Funeral Service Licensee<br>  |  |  |                                 | 22. Name and Address of Facility<br><u>Holloway Funeral Home</u><br><u>501 Snow Hill Rd., Salisbury, MD 21804</u>                                 |   |   |   |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |                                 |   |   |   |   | Approximate Interval Between Onset and Death  |
| Immediate Cause (Final disease or condition resulting in death)<br><u>Cerebral Hemorrhage</u>  |  |  |                                 |   |   |   |   | <u>24 hrs</u>   |
| Due to (or as a consequence of):<br><u>HTN</u>   |  |  |                                 |   |   |   |   | <u>~</u>  |
| Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  |  |  |                                 |   |   |   |   |   |
| Due to (or as a consequence of):   |  |  |                                 |   |   |   |   |   |
| Due to (or as a consequence of):   |  |  |                                 |   |   |   |   |   |
| Due to (or as a consequence of):   |  |  |                                 |   |   |   |   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>COPD</u>  |  |  |                                 |   |   |   |   |   |
| 23b. Did tobacco use contribute to the cause of death?<br><u>1</u> Yes <u>2</u> No <u>3</u> <input checked="" type="checkbox"/> Probably <u>4</u> Unknown  |  |  |                                 |   |   |   |   |   |
| 24a. Was an autopsy performed?<br><u>1</u> Yes <u>2</u> <input checked="" type="checkbox"/> No   |  |  |                                 |   |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><u>1</u> Yes <u>2</u> <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><u>1</u> Yes <u>2</u> <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA Other: <u>4</u> Nursing Home <u>5</u> Residence <u>8</u> Other (Specify) |                                 |   |   |   |   |   |
| 27. Manner of Death<br><u>1</u> Natural <u>5</u> Pending Investigation<br><u>2</u> Accident <u>6</u> Could not be determined<br><u>3</u> Suicide <u>4</u> Homicide   |  | 28a. Date of Injury (Month, Day Year)  |                                 | 28b. Time of Injury<br>M  |   | 28c. Injury at Work?<br><u>1</u> Yes <u>2</u> No            |   | 28d. Describe how injury occurred   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |                                 | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |   |   |
| 29a. Certifier (Check only one)<br><u>1</u> <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><u>2</u> <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |                                 |   |   |   |   |   |
| 29b. Signature and title of certifier<br> P.O.  |  |  |                                 | 29c. License number<br><u>HSD 457</u>   |   | 29d. Date signed (Month, Day, Year)<br><u>12/7/97</u>       |   |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><u>CHRISTOPHER SNYDER, 208 PINE BLUFF RD. SALISBURY, MD. 21801</u>   |  |  |                                 |   |   |   |   |   |
| 31. Date filed (Month, Day, Year)<br><u>DEC 10 1997</u>  |  |  |                                 | 32. Registrar's Signature<br>                                  |   |   |   |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39903

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Barbara Ann Nichols

2. Date of Death

December 7, 1997

3. Time of Death

2212

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

215-58-5810

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

46

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 20, 1951

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomic

10c. City, Town or Location

Pocomoke

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

33617 Costen Road

10f. Zip Code

21851

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Maintenance

17. Father's Name (First, Middle, Last)

Charlie McBride

18. Mother's Name (First, Middle, Maiden Surname)

Corrine Merrill

19a. Informant's Name/Relationship (Type, Print)

Eugene I. Nichols (husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

33617 Costen Rd., Pocomoke, Maryland 21851

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Trinity U.M. church Cem.

Date

12/13/97 Unionville, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bennie Smith Funeral Home  
P.O. Box 1687, Easton, Maryland 21601

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Demyelinating Polyneuropathy

Due to (or as a consequence of):

b. Pleural Effusion

Due to (or as a consequence of):

c. Malignant Polyps s/p hemicolectomy

Due to (or as a consequence of):

d. Renal Insufficiency

Approximate Interval Between Onset and Death

7/97

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Malnutrition

Anemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Chesapeake Rehab Hosp

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

M45955

29d. Date signed (Month, Day, Year)

12-7-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Jeffrey W. Anderson, D.O.

100 E. Carroll St. Salisbury, MD PRMC #383 21801

31. Date filed (Month, Day, Year)

DEC 12 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Division of Vital Records, P.O. Box 68760,

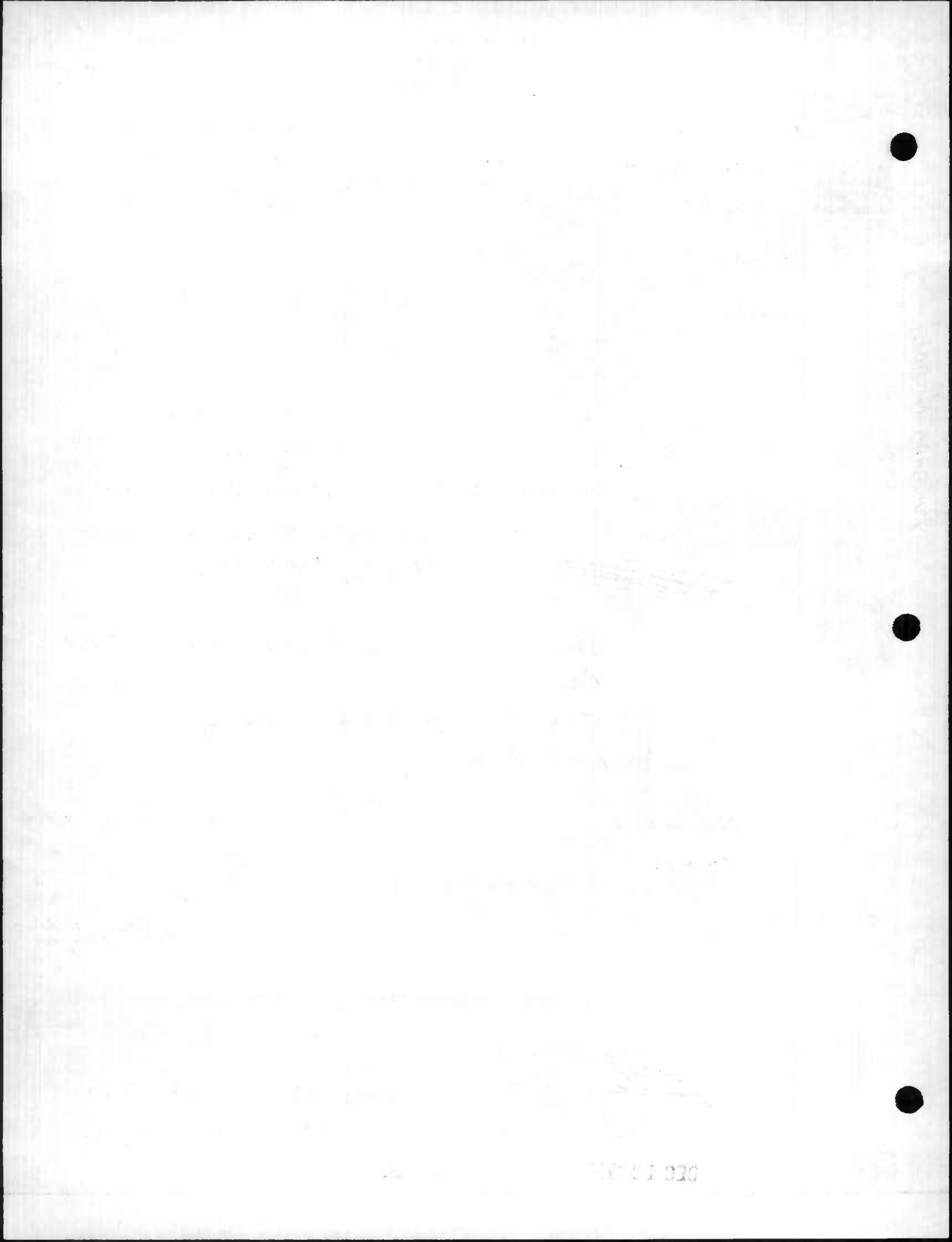
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

BARBARA NICHOLS



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

37 39904

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |   |   |
|---|--|---|--|---|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Floyd EDWARD Patrick</b>   |  | 2. Date of Death<br>Month <b>Dec</b> Day <b>8</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>5:18 AM</b>  |   |
| 4a. Facility Name (If not institution, give street and number)<br><b>Genesis ElderCare - The Pines</b>  |  |   | 4b. City, Town, or Location of Death<br><b>Easton</b>  |   | 4c. County of Death<br><b>Talbot</b>                        |
| 5. Social Security Number<br><b>217-07-9535</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>93</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>SEPT. 11, 1904</b>  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b> |
| Usual Residence of Decedent   |  |   |  |   |   |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>TALBOT</b>  |  | 10c. City, Town or Location<br><b>EASTON</b>  |   |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |   |   |
| 10e. Street and Number<br><b>704 GOLDSBOROUGH ST.</b>   |  |   | 10f. Zip Code<br><b>21601</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>                 |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - it Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |   |  |   |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b><br>College (14 or 5+) <b>-0-</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CARPENTER</b>   |  | 16b. Kind of Business/Industry<br><b>HOUSING INDUSTRY</b>   |   |
| 17. Father's Name (First, Middle, Last)<br><b>JAMES DAVID PATRICK</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>EMMA COLE</b>  |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>CLAUDE M. PATRICK/ SON</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>704 GOLDSBOROUGH ST., EASTON, MD 21601</b> |   |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>SPRING HILL CEMETERY</b>   |  | 20c. Location - City or Town, State<br><b>12-11 EASTON, MD 21601</b>  |   |
| 21. Signature of Funeral Service Licensee<br><b>JOHN R. MERCERON</b>  |  |   | 22. Name and Address of Facility<br><b>FELLOWS, HELFENBEIN &amp; NEWMAN FUNERAL HOME<br/>200 S. HARRISON ST., EASTON, MD 21601</b>             |   |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>prostate cancer</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>months</b><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |  |   |  |   |   |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |   |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |   |
| 28c. Injury et Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |   |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |   |   |
| 29b. Signature and title of certifier<br><b>R. B. SANCHEZ M.D.</b>  |  | 29c. License number<br><b>D25150</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>12/8/97</b>   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ROBERT B. SANCHEZ M.D. 500 Edgewild Ave Easton MD 21601</b>  |  |   |  |   |   |
| 31. Date filed (Month, Day, Year)<br><b>DEC 09 1997</b>   |  | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>  |  |   |   |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

87 39905

|   |  |  |  |  |   |  |   |  |
|---|--|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>WILLIAM PURNELL PHILLIPS</b>  |  |  |  | 2. Date of Death<br>Month <b>December</b> Day <b>8</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>0810</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>PENINSULA REGIONAL MEDICAL CENTER</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>SALISBURY</b>  |  | 4c. County of Death<br><b>WICOMICO</b>                                  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-03-2177</b>  |  | 6. Sex<br><b>1</b> M <b>2</b> F  |  | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>3/29/18</b>                   |  |
|   | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Worcester</b>  |  | 10c. City, Town or Location<br><b>Eden</b>  |  | 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No                     |  |
| To Be Completed by Funeral Director   | 10e. Street and Number<br><b>1926 Old Furnace Road</b>   |  |  |  | 10f. Zip Code<br><b>21822</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>                             |  |
|   | 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Poultryman</b>   |  | 16b. Kind of Business/Industry<br><b>Poultry</b>  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Walter Burton Phillips</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Beulah Mae Phillips</b>   |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Estelle M. Phillips/Wife</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1926 Old Furnace Rd., Eden, MD 21822</b>      |  |   |  |
|   | 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parsons Cemetery</b>  |  | Date<br><b>12/12/97</b>   |  | 20c. Location - City or Town, State<br><b>Salisbury, MD</b>             |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |  |  | 22. Name and Address of Facility<br><b>Holloway Funeral Home</b><br><b>501 Snow Hill Rd., Salisbury, MD 21804</b>                                 |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Coronary Artery Disease</b><br>Due to (or as a consequence of):<br>b. <b>Myocardial Infarction</b><br>Due to (or as a consequence of):<br>c. <b>Chronic Heart Failure</b><br>Due to (or as a consequence of):<br>d.<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |  |   |  |   |  |
|   | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Gastrointestinal Bleeding</b>  |  |  |  |   |  |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown  |  |  |  |   |  |   |  |
| 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No  |  |  |  |  |   |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No |  |  |  |  |   |  |   |  |
| Physician<br>/Medical<br>Examiner   | 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No   |  | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |  |   |  |   |  |
|   | 27. Manner of Death<br><b>1</b> Natural <b>5</b> Pending investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide   |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No                        |  |
|   | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |   |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |   |  |
| To Be Completed by Physician/Medical Examiner   | 29a. Certifier (Check only one)<br><b>1</b> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
|   | 29b. Signature and title of certifier<br>   |  |  |  | 29c. License number<br><b>040715</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>12/8/97</b>                   |  |
|   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Steven Hearn, M.D. 400 Eastern Shore Dr., Salisbury, Md.</b>  |  |  |  |   |  |   |  |
|   | 31. Date filed (Month, Day, Year)<br><b>DEC 12 1997</b>  |  | 32. Registrar's Signature<br>   |  |   |  |   |  |



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State of Maryland / Department of Health and Mental Hygiene 97 39906

## Certificate of Death

Reg. No.

|   |  |   |  |  |   |  |  |   |  |
|---|--|---|--|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>VIRGINIA CLARA PATON</b>                          |   |  |  | 2. Date of Death<br>Month <b>December</b> Day <b>4</b> Year <b>1997</b> |  | 3. Time of Death<br><b>11:05 PM</b>  |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>1603 S. Division Street</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Salisbury</b>                |  | 4c. County of Death<br><b>Wicomico</b>   |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>439-28-7333</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>70</b> Yrs. | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Days  | 6. Date of Birth (Month, Day, Year)<br><b>8/20/27</b>  | 9. Birthplace (State or Foreign Country)<br><b>Oklahoma</b>                                    |   |  |
|   | Usual Residence of Decedent  |   |  |  |   |  |  |   |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Wicomico</b>  |  | 10c. City, Town or Location<br><b>Salisbury</b>  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
| 10e. Street and Number<br><b>1603 S. Division Street</b>  |  |   |  | 10f. Zip Code<br><b>21801</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>-</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Nurse</b>  |   |  | 16b. Kind of Business/Industry<br><b>Nursing</b>   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Asa Clyde Weed</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Clarice Iona Ethridge</b>  |   |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Clyde Paton/Son</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4417 N. 4th St., Apt. 2, Arlington, VA 22203</b>   |   |  |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Salisbury Crematory</b>  |  |  | Date<br><b>12/8/97</b>  |  | 20c. Location - City or Town, State<br><b>Salisbury, MD</b>                                    |   |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Holloway Funeral Home</b><br><b>501 Snow Hill Rd., Salisbury, MD 21804</b>  |   |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Squamous Cell Head and Neck</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |  | Approximate interval Between Onset and Death<br><b>9 mo</b>  |   |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |  |
|   |  |   |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |
|   |  |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred                     |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  | 29b. Signature and Title of certifier<br>  |   | 29c. License number<br><b>D 20507</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>12/8/97</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Joseph A. Grasso 145 E. Carroll St. Salisbury MD</b>   |  |   |  |  |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 10 1997</b>   |  |   |  | 32. Registrar's Signature<br>  |   |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 39907**  
Certificate of Death

Reg. No.

|   |   |                                 |   |  |  |  |   |  |   |                                 |  |  |    |                                |    |  |    |  |  |  |  |  |  |
|---|---|---------------------------------|---|--|--|--|---|--|---|---------------------------------|--|--|----|--------------------------------|----|--|----|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>CHARLES RAYMOND RISHEL</b>   |                                 |   |  | 2. Date of Death<br>Month <b>DEC.</b> Day <b>4</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>8:10 AM</b>                                      |  |   |                                 |  |  |    |                                |    |  |    |  |  |  |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>5236 LANDING NECK ROAD</b>   |                                 |   |  | 4b. City, Town, or Location of Death<br><b>TRAPPE</b>  |  | 4c. County of Death<br><b>TALBOT</b>                                    |  |   |                                 |  |  |    |                                |    |  |    |  |  |  |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>179-16-7534</b>   |                                 | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.                             | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>OCT. 17, 1917</b>             |  |   |                                 |  |  |    |                                |    |  |    |  |  |  |  |  |  |
|   | Usual Residence of Decedent   |                                 | 9. Birthplace (State or Foreign Country)<br><b>PA</b>   |  |  |  |   |  |   |                                 |  |  |    |                                |    |  |    |  |  |  |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>   | 10b. County<br><b>TALBOT</b>    | 10c. City, Town or Location<br><b>TRAPPE</b>  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |   |                                 |  |  |    |                                |    |  |    |  |  |  |  |  |  |
|   | 10e. Street and Number<br><b>5236 LANDING NECK ROAD</b>   |                                 |   | 10f. Zip Code<br><b>21673</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |   |                                 |  |  |    |                                |    |  |    |  |  |  |  |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |   |                                 |  |  |    |                                |    |  |    |  |  |  |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b>   |                                 | College (1-4 or 5+) <b>-0-</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SAWYER</b>   |  | 16b. Kind of Business/Industry<br><b>LOGGING</b>                        |  |   |                                 |  |  |    |                                |    |  |    |  |  |  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>HARRY RISHEL</b>  |                                 |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>FRANCES HERMAN</b>   |  |   |  |   |                                 |  |  |    |                                |    |  |    |  |  |  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>SUSANNA DEIBEL/ DAUGHTER</b>   |                                 |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. BOX 424, EASTON, MD 21601</b>   |  |   |  |   |                                 |  |  |    |                                |    |  |    |  |  |  |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |                                 | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>LANDING NECK CEMETERY</b>  |  | Data<br><b>12-8</b>  |  | 20c. Location - City or Town, State<br><b>TRAPPE, MD</b>                |  |   |                                 |  |  |    |                                |    |  |    |  |  |  |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Manna &amp; Manna</i>   |                                 | 22. Name and Address of Facility<br><b>FELLOWS, HELFENBEIN &amp; NEWNAM FUNERAL HOME</b><br><b>200 S. HARRISON ST., EASTON, MD 21601</b>          |  |  |  |   |  |   |                                 |  |  |    |                                |    |  |    |  |  |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |                                 |   |  |  |  |   |  |   |                                 |  |  |    |                                |    |  |    |  |  |  |  |  |  |
|   | <table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td><i>Cardiac arrhythmia</i></td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b.</td> <td><i>Coronary artery disease</i></td> </tr> <tr> <td>c.</td> <td><i>Atherosclerosis</i></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> |                                 |   |  |  |  |   |  | Immediate Cause (Final disease or condition resulting in death)   | a.                              | <i>Cardiac arrhythmia</i>  | Approximate Interval Between Onset and Death   | b. | <i>Coronary artery disease</i> | c. | <i>Atherosclerosis</i>   | d. |  |  |  |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)   | a.  | <i>Cardiac arrhythmia</i>       | Approximate Interval Between Onset and Death  |  |  |  |   |  |   |                                 |  |  |    |                                |    |  |    |  |  |  |  |  |  |
|   | b.  | <i>Coronary artery disease</i>  |   |  |  |  |   |  |   |                                 |  |  |    |                                |    |  |    |  |  |  |  |  |  |
|   | c.  | <i>Atherosclerosis</i>          |   |  |  |  |   |  |   |                                 |  |  |    |                                |    |  |    |  |  |  |  |  |  |
|   | d.  |                                 |   |  |  |  |   |  |   |                                 |  |  |    |                                |    |  |    |  |  |  |  |  |  |
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| <table border="0"> <tr> <td>24a. Was an autopsy performed?<br/><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td colspan="3">24b. Were autopsy findings available prior to completion of cause of death?<br/><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table>   |   |                                 |   |  |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |                                 |  |  |    |                                |    |  |    |  |  |  |  |  |  |
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| <table border="0"> <tr> <td>25. Was case referred to medical examiner?<br/><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> <td colspan="3">28. Place of Death (Check only one)<br/>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)</td> </tr> </table>  |   |                                 |   |  |  |  |   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 28. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                 |  |  |    |                                |    |  |    |  |  |  |  |  |  |
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| <table border="0"> <tr> <td>27. Manner of Death<br/><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined</td> <td>28a. Date of Injury (Month, Day, Year)</td> <td>28b. Time of Injury<br/><b>M</b></td> <td>28c. Injury at Work?<br/><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td colspan="4">28d. Describe how injury occurred</td> </tr> <tr> <td colspan="4">28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</td> <td colspan="4">28f. Location (Street and Number or Rural Route Number, City or Town, State)</td> </tr> </table> |   |                                 |   |  |  |  |   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  | 28a. Date of Injury (Month, Day, Year)  | 28b. Time of Injury<br><b>M</b> | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | 28d. Describe how injury occurred  |    |                                |    | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |    |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |  |
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| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |                                 |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |   |  |   |                                 |  |  |    |                                |    |  |    |  |  |  |  |  |  |
| <table border="0"> <tr> <td>29a. Certifier (Check only one)<br/><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</td> <td colspan="2">29b. Signature and title of certifier<br/><i>Michael D. Crowley, Jr.</i></td> <td>29c. License number<br/><b>025933</b></td> <td colspan="4">29d. Date signed (Month, Day, Year)<br/><b>12.5.97</b></td> </tr> </table>   |   |                                 |   |  |  |  |   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | 29b. Signature and title of certifier<br><i>Michael D. Crowley, Jr.</i>   |                                 | 29c. License number<br><b>025933</b>   | 29d. Date signed (Month, Day, Year)<br><b>12.5.97</b>  |    |                                |    |  |    |  |  |  |  |  |  |
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| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MICHAEL D. CROWLEY, JR., M.D., 508 IDLEWILD AVENUE, EASTON, MD 21601</b>   |   |                                 |   |  |  |  |   |  |   |                                 |  |  |    |                                |    |  |    |  |  |  |  |  |  |
| <table border="0"> <tr> <td>31. Date filed (Month, Day, Year)<br/><b>DEC 08 1997</b></td> <td colspan="7">32. Registrar's Signature<br/><i>John Davidson-Rendall</i></td> </tr> </table>  |   |                                 |   |  |  |  |   | 31. Date filed (Month, Day, Year)<br><b>DEC 08 1997</b>  | 32. Registrar's Signature<br><i>John Davidson-Rendall</i>   |                                 |  |  |    |                                |    |  |    |  |  |  |  |  |  |
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Baltimore, Maryland 21215-0020

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Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



25

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39908

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Susan M Ricker

2. Date of Death  
Month Day Year

DECEMBER 10, 1997

3. Time of Death  
09:46 AM

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

221-44-5016

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

43 Yrs.

If Under 1 Year  
Months Days

If Under 24 Hrs.  
Hours Min.

8. Date of Birth  
(Month, Day, Year)

DEC 2, 1954

9. Birthplace (State or Foreign  
Country)

MILFORD, DE

Usual Residence of Decedent

10a. State

DELAWARE

10b. County

SUSSEX

10c. City, Town or Location

GEORGETOWN

10d. Inside City Limits  
1 ☒ Yes 2 ☐ No

10e. Street and Number

210 W. MARKET STREET

10f. Zip Code

19947

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married

3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.  
Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

5

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

REGISTERED NURSE

16b. Kind of Business/Industry

HEALTHCARE

17. Father's Name (First, Middle, Last)

VINCENT J. SEARS, SR.

18. Mother's Name (First, Middle, Maiden Surname)

RUTH SWENSON

19a. Informant's Name/Relationship (Type, Print)

CHARLES J. RICKER (HUSBAND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

210 W. MARKET STREET, GEORGETOWN, DE 19947

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of  
cemetery, crematory or other place)

UNION CEMETERY

Date

12-14

20c. Location - City or Town, State

GEORGETOWN, DE

21. Signature of Funeral Service Licensee

George M Short

22. Name and Address of Facility

SHORT FUNERAL SERVICES, INC.

609 E. MARKET STREET, GEORGETOWN, DE 19947

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a. Sepsis  
Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

8 days

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Immunosuppression  
Due to (or as a consequence of):

1 year

c. Metastatic Hemangiopericytoma  
Due to (or as a consequence of):

13 years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Thrombocytopenia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy  
performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical  
examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending  
Investigation

6 ☐ Could not be  
determined

28a. Date of Injury  
(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier  
(Check only  
one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Mark Mofid

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

December 10, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark Mofid, MD, 600 North Wolfe Street, Baltimore, Maryland 21287

31. Date filed (Month, Day, Year)

DEC 12 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 97 39909

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Helen SAVAGE

2. Date of Death

Month Day Year  
12 - 03 - 1997

3. Time of Death

6:30A.M.

4a. Facility Name (If not institution, give street and number)

Anne Arundel Hospital

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

212-16-7784

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
06-09-1908

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Queen Anne

10c. City, Town or Location

Centreville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

205 Armstrong Ave.

10f. Zip Code

21617

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:  
Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
3rd

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Regina Smith (cousin)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

141 Watkins Rd., Grasonville, Maryland 21638

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Robinson AME Church Cem. 12/8/97

Data

20c. Location - City or Town, State

Grasonville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bennie Smith Funeral Home  
P.O. Box 1687, Easton, Maryland 21601

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

Renal Failure

b.

Due to (or as a consequence of):

Diabetes

c.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

d.

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 week

2 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia, Polycythemia vera

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and manner stated.

29b. Signature and title of certifier

Gary Spruance

29c. License number

032056

29d. Date signed (Month, Day, Year)

12/14/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gary Spruance 2108 D. Pomato Drive Clark, MD 21619

31. Date filed (Month, Day, Year)

DEC 11 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

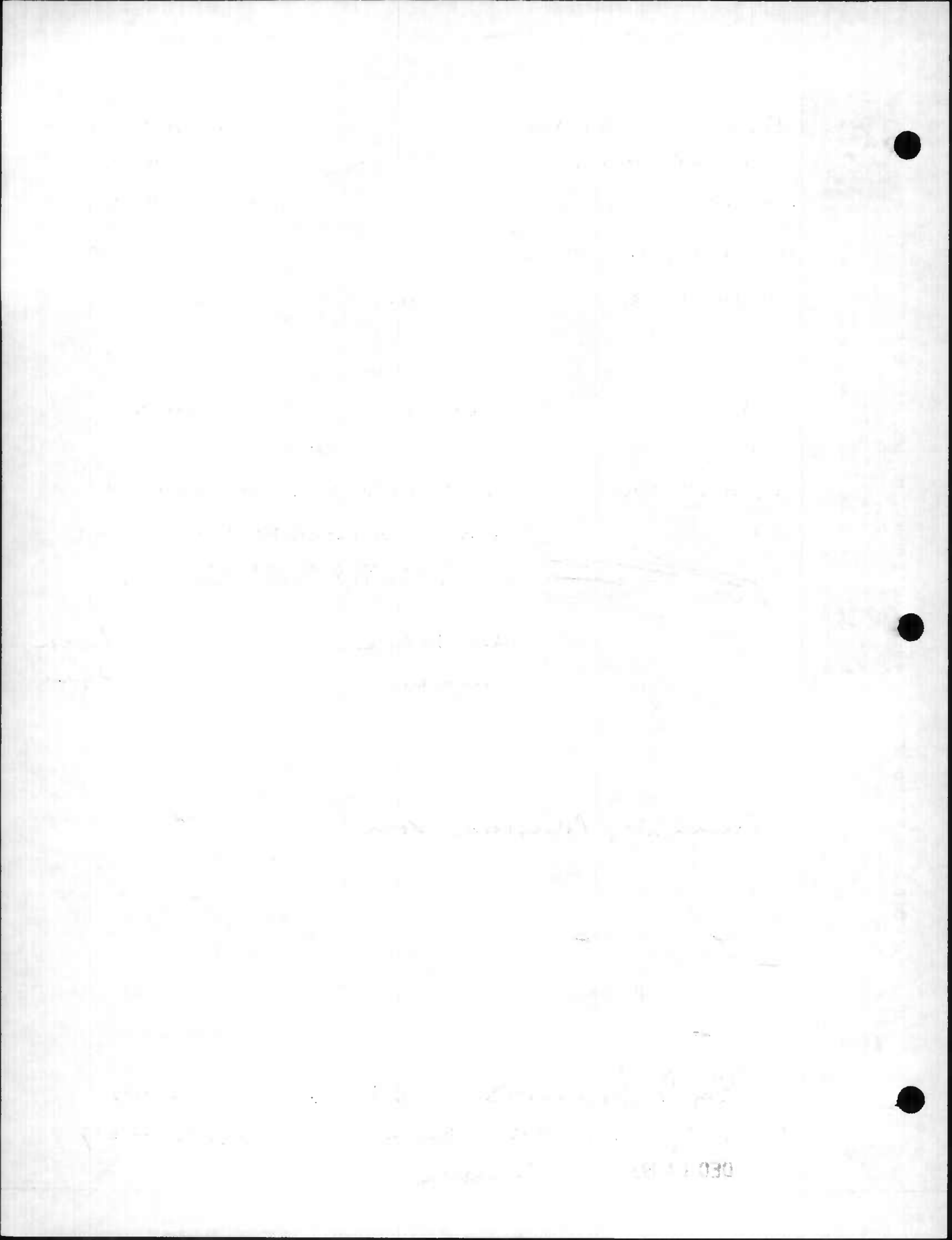
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended #19a, 12/12/97, TCHD, bjb

Certificate of Death

Reg. No.

97 39910

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Elizabeth Sample

2. Date of Death

Month Day Year  
DEC 10 1997

3. Time of Death

8:08 AM

4a. Facility Name (If not institution, give street and number)

THE MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

EASTON

4c. County of Death

TALBOT

5. Social Security Number

218-24-5374

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 24, 1930

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Caroline

10c. City, Town or Location

Denton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

25875 Sennet Rd.

10f. Zip Code

21629

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Factory Work

17. Father's Name (First, Middle, Last)

Harold Cannon

18. Mother's Name (First, Middle, Maiden Surname)

Evelyn Dickerson

19a. Informant's Name/Relationship (Type, Print)

Harry C. Sample, Sr.  
~~Harold Sample~~ (husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

25875 Sennet Rd., Denton, Maryland 21629

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Federal Hill Cemetery

Date

12/15/97

20c. Location - City or Town, State

Federalsburg, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bennie Smith Funeral Home  
P.O. Box 1687, Easton, Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic heart disease

Due to (or as a consequence of):

b. End stage renal disease with multiple metabolic abnormalities 2 years

Due to (or as a consequence of):

c. Peripheral vascular disease - right foot ulcer

Due to (or as a consequence of):

d. adult onset diabetes mellitus

Approximate Interval Between Onset and Death

4 years

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

aneurysm of chronic disease

Sepsis

anoxic brain damage

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 46020

29d. Date signed (Month, Day, Year)

12/10/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Syed Ali MD, 506 Idlewild Ave., Easton, Maryland 21601

31. Date filed (Month, Day, Year)

DEC 11 1997

32. Registrar's Signature

State  
Registrar

MARY ELIZABETH SAMPLE

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 39911

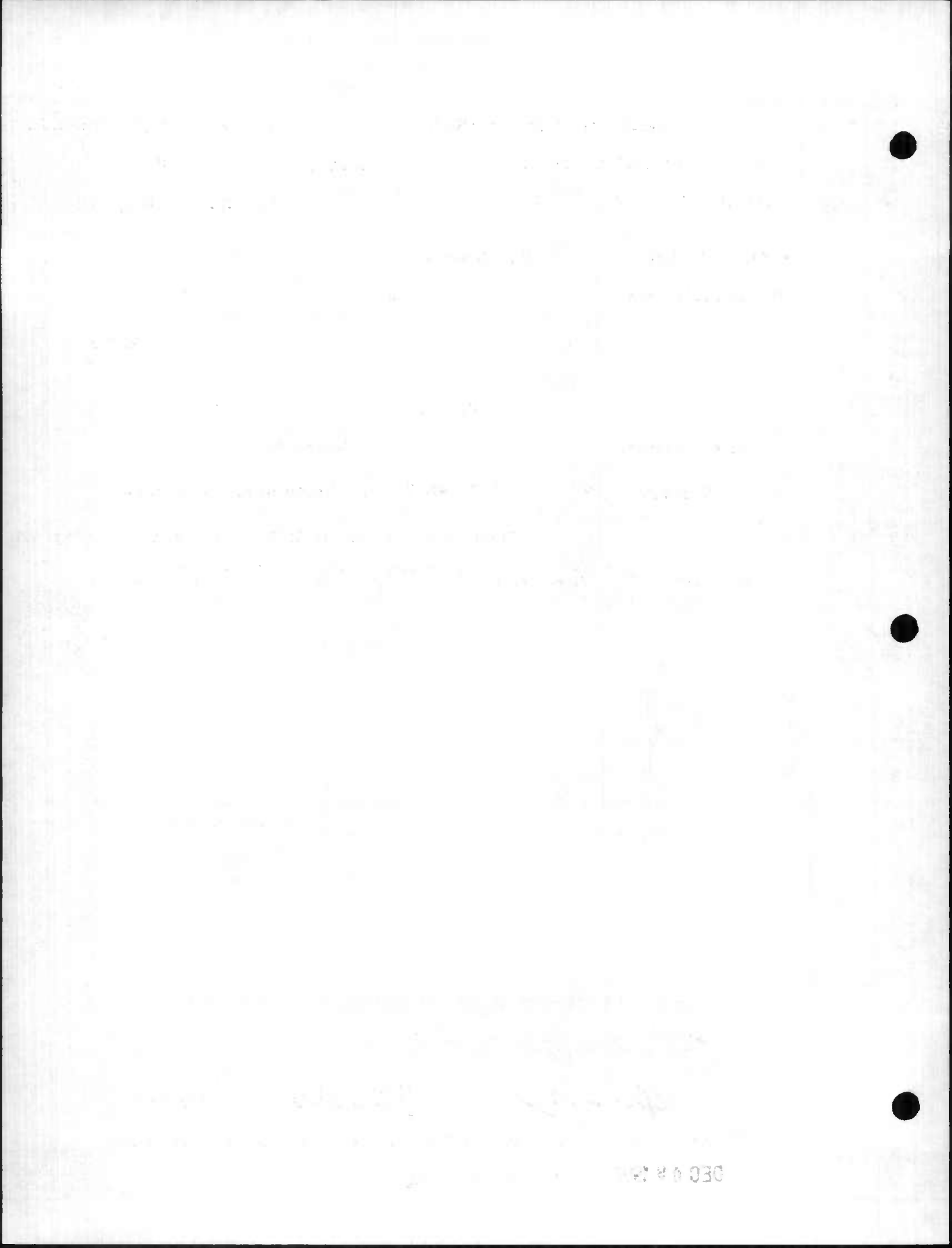
|   |  |  |   |  |   |  |   |   |
|---|--|--|---|--|---|--|---|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ALBERT FAIRBANK SOULSMAN</b>                          |  |   |  | 2. Date of Death<br>Month Day Year<br><b>December 1, 1997</b> |  | 3. Time of Death<br><b>9:45 A.M.</b>                        |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Memorial Hospital at Easton</b> |  |   |  | 4b. City, Town, or Location of Death<br><b>Easton</b>         |  | 4c. County of Death<br><b>Talbot</b>                        |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-14-4825</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.              |  | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 26, 1921</b> |   |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  | 10e. State<br><b>Maryland</b>   |  | 10b. County<br><b>Talbot</b>                                  |  | 10c. City, Town or Location<br><b>St. Michaels</b>          |   |
| Usual Residence of Decedent   |  |  |   |  |   |  |   |   |
| 10e. State<br><b>Maryland</b>   |  |  | 10b. County<br><b>Talbot</b>  |  |   | 10c. City, Town or Location<br><b>St. Michaels</b>   |   |   |
| 10e. Street and Number<br><b>614 Radcliffe Ave.</b>   |  |  | 10f. Zip Code<br><b>21663</b>   |  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+)                        |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Bulk Truck Driver</b>  |   |   |
| 16b. Kind of Business/Industry<br><b>ConAgra</b>  |  |  | 17. Father's Name (First, Middle, Last)<br><b>Walter Soulsman</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Louise Radcliffe</b>   |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Maye S. Soulsman Wife</b>  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 293 St. Michaels, Maryland 21663</b> |  |   |  |   |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Olivet Cemetery</b>  |  |   | 20c. Date<br><b>Dec. 4, 1997</b>   |   |   |
| 20d. Location - City or Town, State<br><b>St. Michaels, Maryland</b>  |  |  | 21. Signature of Funeral Service Licensee<br><b>Harrison E. Leonard</b>   |  |   | 22. Name and Address of Facility<br><b>Harrison E. Leonard Funeral Home<br/>312 S. Talbot St. St. Michaels, Maryland 21663</b>   |   |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |   |  |   |  |   |   |
| Immediate Cause (Final disease or condition resulting in death)<br>a. <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> YEARS<br>Due to (or as a consequence of):  |  |  |   |  |   |  |   |   |
| Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):  |  |  |   |  |   |  |   |   |
| c. Due to (or as a consequence of):   |  |  |   |  |   |  |   |   |
| d. Due to (or as a consequence of):   |  |  |   |  |   |  |   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>SUPRAVENTRICULAR CARDIAC ARRHYTHMIA</b>  |  |  |   |  |   |  |   |   |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |   |  |   |  |   |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |  |   |  |   |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  |   |  |   |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |  |   |  |   |   |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Over/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |   |  |   |  |   |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  |  | 28a. Date of Injury (Month, Day Year)   |  |   | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 28d. Describe how injury occurred   |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |  |   |  |   |   |
| 29b. Signature and title of certifier<br><b>W. Bremer MD</b>  |  |  | 29c. License number<br><b>D26350</b>  |  |   | 29d. Date signed (Month, Day, Year)<br><b>12/3/97</b>  |   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>William S. Bremer M.D. 800 S. Talbot St. St. Michaels, Maryland 21663</b>  |  |  |   |  |   |  |   |   |
| 31. Date filed (Month, Day, Year)<br><b>DEC 09 1997</b>   |  |  | 32. Registrar's Signature<br><b>Julia Davidson-Rendall</b>  |  |   |  |   |   |

Baltimore, Maryland 21215-0020

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

State  
Registrar



REF ID: A6030

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39912

|                                     |  |  |  |  |  |  |   |  |  |  |
|-------------------------------------|--|--|--|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>JOSEFA MARIA SCHLAG</b>   |  |  |  |  |  | 2. Date of Death<br>Month Day Year<br><b>Dec. 3, 1997</b>   |  | 3. Time of Death<br><b>3:30 P.M.</b>   |  |
|                                     | 4a. Facility Name (If not Institution, give street and number)<br><b>8913 Tilghman Island Rd.</b>  |  |  |  |  |  | 4b. City, Town, or Location of Death<br><b>Wittman</b>  |  | 4c. County of Death<br><b>Talbot</b>   |  |
| Funeral<br>Director                 | 5. Social Security Number<br><b>219-74-6950</b>  |  | 8. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.   |  | If Under 1 Year<br>Months Days  |  | If Under 24 Hrs.<br>Hours Min.   |  |
|                                     | 6. Date of Birth (Month, Day, Year)<br><b>July 27, 1915</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Germany</b>   |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Talbot</b>  |  | 10c. City, Town or Location<br><b>Wittman</b>  |  |
| To Be Completed by Funeral Director | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>8913 Tilghman Island Rd.</b>  |  | 10f. Zip Code<br><b>21676</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
|                                     | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: <b>White</b>  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Owner Operator</b>   |  |
|                                     | 16b. Kind of Business/Industry<br><b>Gladiola Farm</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Johann Luken</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anna Schlomar</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Susan A. Townsend Daughter</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8898 Teal Point Rd. Easton, Maryland 21601</b>                                     |  |
|                                     | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Oaklawn Cemetery Dec. 6, 1997</b>   |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>  |  | 21. Signature of Funeral Service Licensee<br><i>Harrison E. Leonard</i>   |  | 22. Name and Address of Facility<br><b>Harrison E. Leonard Funeral Home<br/>312 S. Talbot St. St. Michaels, Maryland 21663</b>   |  |
|                                     | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>SUPRANUCLEAR PALSY</b><br>Due to (or as a consequence of):<br><b>ORGANIC BRAIN SYNDROME</b><br>Due to (or as a consequence of):<br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>HYPERTENSION</b><br><b>RENAL INSUFFICIENCY</b> |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | Approximate Interval Between Onset and Death<br><b>YEARS</b><br><b>YEARS</b>   |  |
|                                     | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  |
|                                     | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><i>William S. Bremer</i>  |  |
|                                     | 29c. License number<br><b>D26350</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>12/5/97</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>William S. Bremer M.D. 800 S. Talbot St. St. Michaels, Maryland 21663</b>   |  | 31. Date filed (Month, Day, Year)<br><b>DEC 09 1997</b>   |  | 32. Registrar's Signature<br><i>Johanna Davidson-Randall</i>   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39914

|   |  |                                  |   |   |  |  |  |  |   |  |
|---|--|----------------------------------|---|---|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>C.F. WILLIAM TILLINGHAST</b>              |                                  |   |   |  |  | 2. Date of Death<br>Month <b>DEC.</b> Day <b>10</b> Year <b>1997</b> |  | 3. Time of Death<br><b>6:00 PM</b>                          |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>500 NESBIT ROAD</b> |                                  |   |   |  |  | 4b. City, Town, or Location of Death<br><b>QUEENSTOWN</b>            |  | 4c. County of Death<br><b>QUEEN ANNE</b>                    |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>213-10-3461</b>  |                                  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>93</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>SEPT. 20, 1904</b>         |  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b> |  |
|   | Usual Residence of Decedent  |                                  |   |   |  |  |  |  |   |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>QUEEN ANNE</b> |   | 10c. City, Town or Location<br><b>QUEENSTOWN</b>  |  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 10e. Street and Number<br><b>500 NESBIT ROAD</b>  |  |                                  |   | 10f. Zip Code<br><b>21658</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |                                  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                        |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>4</b>  |  |                                  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>ENGINEER</b>  |  |  | 16b. Kind of Business/Industry<br><b>CONSTRUCTION</b>                |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>SAMUEL T. TILLINGHAST</b>   |  |                                  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ANNA E.K. SCHLUDERBERG</b>   |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>ANNE T. RILEY/DAUGHTER</b>   |  |                                  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5006 RANDONSTONE LANE, BOWIE, MD 20715</b> |  |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |                                  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>OLD WYE CEMETERY</b>   |  | Data<br><b>12-15</b>   |  | 20c. Location - City or Town, State<br><b>WYE MILLS, MD</b>                                    |   |  |
| 21. Signature of Funeral Service Licensee<br><i>M.E. Newnam</i> <b>CFSP</b>   |  |                                  |   |   |  | 22. Name and Address of Facility<br><b>FELLOWS, HELFENBEIN &amp; NEWNAM FUNERAL HOME</b><br><b>200 S. HARRISON ST., EASTON, MD</b>             |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>e. <b>ADHINO SCLEROTIC CARDIOVASCULAR DISEASE</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |                                  |   |   |  |  |  |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |                                  |   |   |  |  |  |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                                  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No        |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b>   |  |                                  |   |   |  |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                                  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |   |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  |                                  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |   |  |
|   |  |                                  |   | 28d. Describe how Injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |                                  |   |   |  |  |  |  |   |  |
| 29b. Signature and title of certifier<br><i>Ludwig J. Eglseider</i>   |  |                                  |   |   |  | 29c. License number<br><b>D31466</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>12/11/97</b>   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>LUDWIG J. EGLSEDER, III, M.D., 505A DUTCHMAN'S LANE, EASTON, MD</b>  |  |                                  |   |   |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 12 1997</b>   |  |                                  |   | 32. Registrar's Signature<br><i>Johanna Davidson-Randall</i>  |  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 39915

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Nellie Thomas

2. Date of Death

Month  
12Day  
8Year  
97

3. Time of Death

1640

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number

215-20-2612

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Jul. 26 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

10b. County

10c. City, Town or Location

10d. Inside City Limits

☐ Yes ☒ No

Maryland Wicomico

Salisbury

10e. Street and Number

1001 South Delano Avenue

10f. Zip Code

21801

10g. Citizen of What Country?

U.S.A

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

None

17. Father's Name (First, Middle, Last)

Sidney Stanford

18. Mother's Name (First, Middle, Maiden Surname)

Sadie Shockley

19a. Informant's Name/Relationship (Type, Print)

Neola Waller (Cousin)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 1646 Salisbury, Md. 21802

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Acres

Date

12/5

20c. Location - City or Town, State

Salisbury, Md.

21. Signature of Funeral Service Licensee

Bladys B. Stewart

22. Name and Address of Facility

Stewart Funeral Home  
821 West Rd. Salisbury, Md. 21801

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a.

Cardiac Failure

32-45 hours.

Due to (or as a consequence of):

b.

Atherosclerotic myocardial infarction

2 years.

Due to (or as a consequence of):

c.

Dilated cardiomyopathy

many years

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☒ Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

☒ Natural5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☐ Certifying Physician2 ☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Helen M. Baldado MD 16840

29c. License number

29d. Date signed (Month, Day, Year)

12/9/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Helen M. BALDADO MD, 547 F RIVERSIDE DRIVE, SALISBURY MD

31. Date filed (Month, Day, Year)

DEC 15 1997

32. Registrar's Signature

Julie Ann Randall

State  
Registrar

Nellie Thomas

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39916

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>HOWARD EARL WALKER</b>  |  |   |  | 2. Date of Death<br>Month <b>11</b> Day <b>26</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>0815 am</b>   |  |
| 4a. Facility Name (If not Institution, give street and number)<br><b>314 SPRING DRIVE EASTON MD 21601</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>EASTON MD</b>   |  | 4c. County of Death<br><b>TALBOT</b>   |  |
| 5. Social Security Number<br><b>212-10-7943</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>March 18, 1921</b>                                   |  |
| 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |   |  |  |  |  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Talbot</b>  |  | 10c. City, Town or Location<br><b>Easton</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>314 Spring Dr.</b>  |  |   |  | 10f. Zip Code<br><b>21601</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>Navy</b><br>If Yes, Give Year or Dates: <b>WWII</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> Collage (1-4or 5+) <b></b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Plumbing Inspector</b>   |  | 16b. Kind of Business/Industry<br><b>Talbot County</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Frank Henry Walker</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Pauline Dietert</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Margaret W. Walker Wife</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>314 Spring Dr. Easton, Maryland 21601</b>  |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Capitol Crematory Nov. 28, 1997</b>  |  | 20c. Location - City or Town, State<br><b>Dover, Delaware</b>  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Harrison E. Leonard</i>  |  |   |  | 22. Name and Address of Facility<br><b>Harrison E. Leonard Funeral Home</b><br><b>312 S. Talbot St. St. Michaels, Maryland 21663</b>   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Cerebrovascular accident</b><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |  |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>congestive heart failure, Pneumonia</b><br><b>colon cancer</b>  |  |   |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  |
| 28d. Describe how Injury occurred  |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |  |  |
| 29b. Signature and title of Certifier<br><i>[Signature]</i>  |  |   |  | 29c. License number<br><b>D35749</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>11/26/97</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>David G Oliver MD 503 Ditchman Lane Easton MD 21601</b>   |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 09 1997</b>  |  |   |  | 32. Registrar's Signature<br><i>[Signature]</i>  |  |  |  |

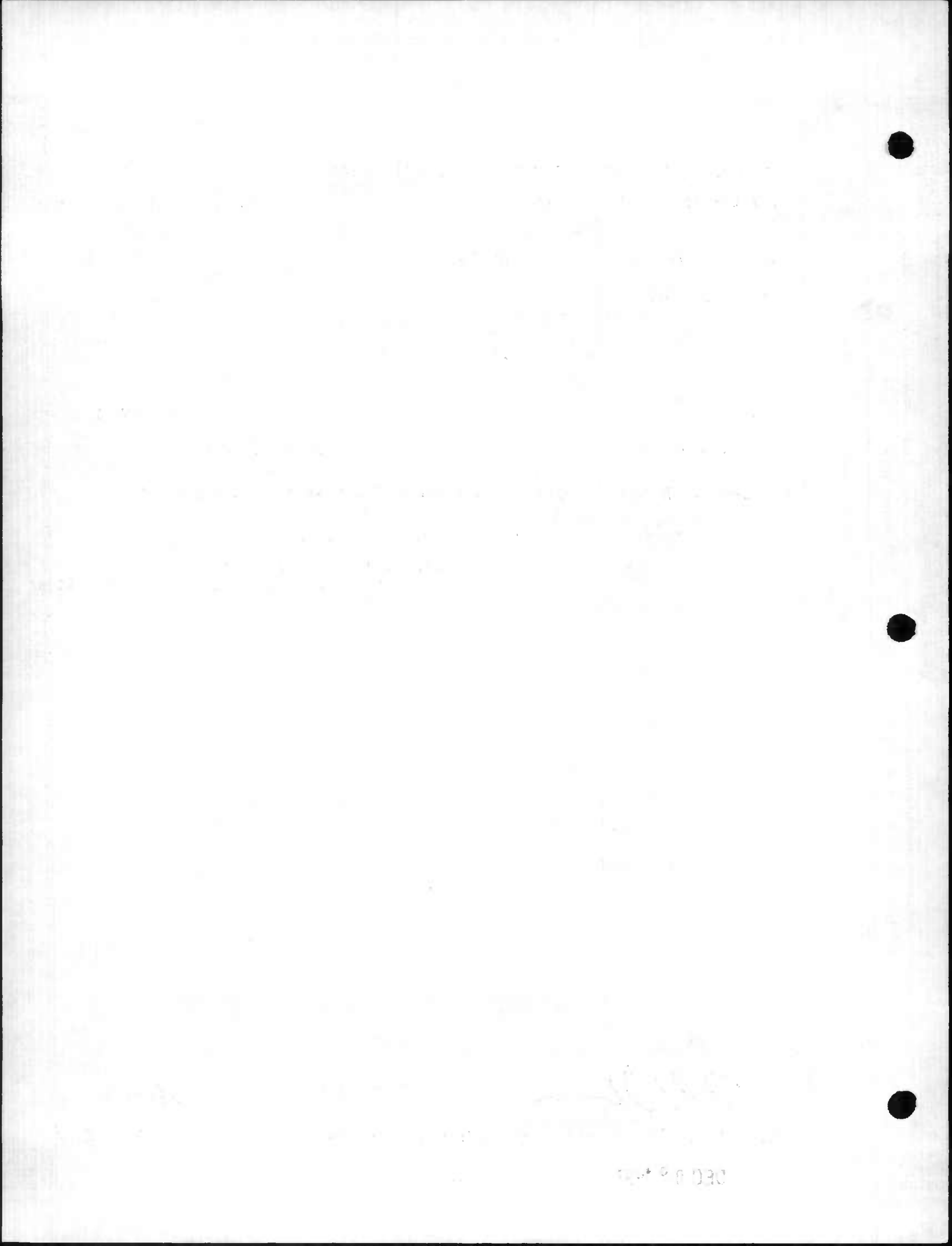
Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 97 39917

Kathryn Westfall  
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>KATHRYN S. WESTFALL</b>   |   | 2. Date of Death<br>Month: <b>Dec</b> Day: <b>3</b> Year: <b>1997</b>   |   | 3. Time of Death<br><b>2:05P</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>The Memorial Hospital</b>   |   |   | 4b. City, Town, or Location of Death<br><b>Easton</b> |  | 4c. County of Death<br><b>Talbot</b>                       |
| 5. Social Security Number<br><b>364-22-9512</b>  | 6. Sex<br><b>1</b> <input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>39</b> Yrs.  | If Under 1 Year<br>Months: Days:                      | If Under 24 Hrs.<br>Hours: Min.  | 8. Date of Birth (Month, Day, Year)<br><b>MAR. 7, 1958</b> |
| 9. Birthplace (State or Foreign Country)<br><b>MICHIGAN</b>  |   |   |   |  |  |
| Usual Residence of Decedent  |   | 10c. City, Town or Location<br><b>EASTON</b>  |   |  |  |
| 10a. State<br><b>MD</b>  | 10b. County<br><b>TALBOT</b>  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |  |
| 10e. Street and Number<br><b>400 WINTON AVENUE</b>   |   | 10f. Zip Code<br><b>21601</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12): <b>N/A</b><br>College (1-4 or 5+): <b>N/A</b>   |   | 16. Kind of Business/Industry<br><b>N/A</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>EARL DNOALD WESTFALL</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>FRANCES RANDALL</b>   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>MARY E. HOLMBERG/ SISTER</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>351 COULBOURNE MILL RD., SALISBURY MD 21804</b>   |   |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory, or other place)<br><b>CHESAPEAKE CREMATION CENTER, L.L.C.</b>   |   | 20c. Location - City or Town, State<br><b>12-5-97 CHESTER, MD</b>  |  |
| 21. Signature of Funeral Service Licensee<br><b>JOHN R. MERLETON (FSP)</b>   |   | 22. Name and Address of Facility<br><b>FELLOWS, HELFENBEIN &amp; NEWNAM FUNERAL HOME<br/>200 S. HARRISON ST., EASTON, MD 21601</b>  |   |  |  |
| 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |   |  |  |
| Immediate Cause (Final disease or condition resulting in death)  |   | e. <b>Cardiac Arrhythmia</b>  |   | 15 min   |  |
|  |   | Due to (or as a consequence of):  |   |  |  |
|  |   | b. <b>Down's Syndrome</b>   |   | Years  |  |
|  |   | Due to (or as a consequence of):  |   |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |   | c. <b>Hypothyroidism</b>  |   | Years  |  |
|  |   | Due to (or as a consequence of):  |   |  |  |
|  |   | d.  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |   |   |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  |
|  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   | 28d. Describe how injury occurred  |  |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |  |  |
| 29b. Signature and title of certifier<br><b>[Signature]</b>  |   | 29c. License number<br><b>125933</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>12-3-97</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MICHAEL D. CROWLEY, JR., M.D., 508 IDLEWILD AVENUE, EASTON, MD 21601</b>  |   |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 08 1997</b>  |   | 32. Registrar's Signature<br><b>[Signature]</b>   |   |  |  |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 97 39918

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WILMA DALE WRIGHT

2. Date of Death

Month Day Year  
December 5, 1997

3. Time of Death

02:41am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Memorial Hospital @ Easton

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

5. Social Security Number

237-34-9009

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
NOV. 8, 1920

9. Birthplace (State or Foreign Country)

NORTH CAROLINA

Usual Residence of Decedent

10a. State

MD

10b. County

TALBOT

10c. City, Town or Location

CORDOVA

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10511 KITTY CORNER ROAD

10f. Zip Code

21625

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

-0-

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

HILLARD COLE

18. Mother's Name (First, Middle, Maiden Surname)

ELLA GARRISON

19a. Informant's Name/Relationship (Type, Print)

CHARLES WRIGHT/HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10511 KITTY CORNER ROAD, CORDOVA, MD 21625

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

FAIRVIEW CEMETERY

Date

12-9-97

20c. Location - City or Town, State

CORDOVA, MD

21. Signature of Funeral Service Licensee

JOHN R. MERCER

22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME  
200 S. HARRISON ST., EASTON, MD 2160123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Pulmonary embolus

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

minutes

b. Atherosclerosis

Due to (or as a consequence of):

years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Non-insulin dependent diabetes

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending  
Investigation 6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

MICHAEL D. CROWLEY, JR., M.D.

29c. License number

DZ5933

29d. Date signed (Month, Day, Year)

12.5.97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL D. CROWLEY, JR., M.D., 508 IDLEWILD AVENUE, EASTON, MD 21601

31. Date filed (Month, Day, Year)

DEC 08 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
RegistrarWilma Wright  
Baltimore, Maryland 21215-0020permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Wilma Wright

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39919

|   |  |  |   |  |  |   |  |  |
|---|--|--|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>RICHARD F. WHITE</b>  |  |   | 2. Date of Death<br>Month <b>DECEMBER</b> Day <b>12</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>3:02 PM</b>  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>SIXTY FOOT ROAD</b>   |  |   | 4b. City, Town, or Location of Death<br><b>PITTSVILLE</b>  |  | 4c. County of Death<br><b>WICOMICO</b>  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>216-70-7177</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>37</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>MAR. 3, 1960</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |  | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>WICOMICO</b>   |   | 10c. City, Town or Location<br><b>WILLARDS</b>   |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>9165 GREENBRANCH ROAD</b>  |  | 10f. Zip Code<br><b>21874</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:           |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>FOREMAN</b>                                 |  | 16b. Kind of Business/Industry<br><b>UTILITIES</b>   |   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>RAYMOND F. WHITE</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>FRANCES SMITH</b>   |  |  |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>HEATHER M. COHEN/DAUGHTER</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>330 WARLICK ST., JACKSONVILLE, NORTH CAROLINA 28540</b> |  |  |   |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>WILLARDS CEMETERY</b>  |  | Date<br><b>12/17/97</b>  |   | 20c. Location - City or Town, State<br><b>WILLARDS, MARYLAND</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 19975</b>  |  |  |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. MULTIPLE INJURIES</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d.</b> |  |   |  |  |   | Approximate Interval Between Onset and Death   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|   | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No          |  |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>WOODED AREA</b> |   |  |  |   |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)<br><b>12/11/1997</b>  |   | 28b. Time of Injury<br><b>10:30 P<sup>M</sup></b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred<br><b>PILOT OF PLANE THAT CRASHED IN WOODED AREA</b>  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>WOODS</b>   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>WICOMICO COUNTY, MARYLAND</b> |  |   |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>O.C.M.E.</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>DECEMBER 13, 1997</b>                             |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>DONALD G. WRIGHT M.D. 111 Penn Street, Baltimore, Maryland 21201</b>   |  |  |   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 15 1997</b>   |  | 32. Registrar's Signature<br>  |   |  |  |   |  |  |

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39920

|   |  |  |  |   |  |  |  |  |   |  |  |
|---|--|--|--|---|--|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>EARL WHITE</b>  |  |  |   | 2. Date of Death<br>Month: <b>12</b> Day: <b>6</b> Year: <b>1997</b> |  |  |  | 3. Time of Death<br><b>11:40 AM</b>                         |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>SALISBURY CENTER: GENESIS ELDERCARE</b> |  |  |   | 4b. City, Town, or Location of Death<br><b>SALISBURY</b>             |  |  |  | 4c. County of Death<br><b>WICOMICO</b>                      |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>220-28-0565</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs.                     |  | 8. Date of Birth (Month, Day, Year)<br><b>2/11/28</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |  |  |
|   | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Wicomico</b>   |   | 10c. City, Town or Location<br><b>Salisbury</b>                      |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |  |  |
| 10e. Street and Number<br><b>27582 Walnut tree Road</b>   |  | 10f. Zip Code<br><b>21801</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Waterman</b> |  | 16b. Kind of Business/Industry<br><b>Seafood</b>  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>John White</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lillie White</b>  |  |  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Laura V. White/Wife</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>27582 Walnut Tree Rd., Salisbury, MD 21801</b>   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Siloam Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>12/10/97 Siloam, MD</b>  |  | 21. Signature of Funeral Service Licensee<br><b>David H. Thompson</b>  |   | 22. Name and Address of Facility<br><b>Holloway Funeral Home<br/>501 Snow Hill Rd., Salisbury, MD 21804</b>  |  |
| 23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>Pneumonia</b><br>Due to (or as a consequence of):<br><b>Dementia + Severe Debility</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Chronic Cardiovascular Blockage</b><br><b>History of Stroke</b><br><b>Diabetes</b><br><b>Post-coronary Bypass</b> |  |  |  |   |  |  |  |  |   | Approximate Interval Between Onset and Death<br><b>11 Days</b>   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Cardiovascular Blockage</b><br><b>History of Stroke</b><br><b>Diabetes</b><br><b>Post-coronary Bypass</b>  |  |  |  |   |  |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |  | 29b. Signature and title of certifier<br><b>[Signature]</b>   |  | 29c. License number<br><b>D39513</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>12/8/97</b>  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Mr. ARKINS MD 1104 Westbury Drive, Salisbury MD 21804</b>  |  |  |  |   |  |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 10 1997</b>   |  |  |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |  |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 97 39921

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lillian

Wagner

2. Date of Death

Month Day Year  
December 7, 1997

3. Time of Death

7:55 PM

4a. Facility Name (If not institution, give street and number)

Salisbury Center: Genesis ElderCare

4b. City, Town, or Location of Death

Salisbury, MD

4c. County of Death

Wicomico

Funeral  
Director

5. Social Security Number

147-12-7586

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

7/3/14

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Pittsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

34576 Old Ocean City Road

10f. Zip Code

21850

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sales/Manager

16b. Kind of Business/Industry

Department Store

17. Father's Name (First, Middle, Last)

Milton Columbus Pusey

18. Mother's Name (First, Middle, Maiden Surname)

Ola Belle Nutter

19a. Informant's Name/Relationship (Type, Print)

Bob Jentsch/Son-in-law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

106 Pacific Ave., Collingswood, NJ 08108

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington Cemetery

Date

12/11/97 Pensauken, NJ

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Holloway Funeral Home

501 Snow Hill Rd., Salisbury, MD 21804

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Empty stomach  
Due to (or as a consequence of):

yrs.

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that is related to the resulting in death) Last

b. Hypertension  
Due to (or as a consequence of):

yrs.

c. Coronary artery disease  
Due to (or as a consequence of):

yrs.

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William Robbins

1104 Healthway Dr., Salisbury, MD 21804

31. Date filed (Month, Day, Year)

DEC 10 1997

32. Registrar's Signature

John Davidson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39922

|  |  |   |  |   |  |   |   |   |  |
|--|--|---|--|---|--|---|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>AKIL MARTIN BRASWELL</b>                              |   |  |   | 2. Date of Death<br>Month Day Year<br><b>DECEMBER 28, 1997</b> |   | 3. Time of Death<br><b>2257PM</b>                         |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>2124 CALLOW AVENUE-SIDEWALK</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE CITY</b>  |   | 4c. County of Death<br><b>NA</b>                          |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>138-70-0057</b>  |   | 8. Sex<br><b>XX</b> M 2 <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>19</b> Yrs.               |   | 6. Date of Birth (Month, Day, Year)<br><b>MAY 24 1978</b> |   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>PA</b>  |   | 10a. State<br><b>MD</b>                            |   | 10b. County<br><b>NA</b>                                       |   | 10c. City, Town or Location<br><b>BALTIMORE</b>           |   |  |
| Usual Residence of Decedent  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>2418 CALLOW AVENUE</b>   |  | 10f. Zip Code<br><b>21217</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>   |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:         |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>   |   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b><br>College (1-4or 5+) <b>NA</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Banquet Servicer</b>                          |  | 16b. Kind of Business/Industry<br><b>Rustic Lodge</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>JOE H. BRASWELL</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>WILHELMENA ROBINSON</b>   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Joe Braswell - Father</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2418 Callow Ave. Balto., Md 21217</b>                     |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>King Memorial Park</b>   |   | 20c. Location - City or Town, State<br><b>1-3-98 Randallstown, Md</b>   |  |
| 21. Signature of Funeral Service Licensee<br><b>Dennis B. Harris</b>   |  | 22. Name and Address of Facility<br><b>Wm. C. March Funeral Home West, Inc.<br/>4300 Wabash Ave. Balto., Md. 21215</b>  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Multiple Gunshot Wounds of the Head</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   | 24a. Was an autopsy performed?<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> |  | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>AT SCENE</b> |   | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide |  |
| 28a. Date of Injury (Month, Day, Year)<br><b>12/28/97</b>  |  | 28b. Time of Injury<br><b>2257P</b> M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred<br><b>subject shot</b>  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>street</b>   |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>Dennis J. Chute MD</b>  |  | 29c. License number<br><b>O.C.M.E.</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>DECEMBER 29, 1997</b>   |   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201</b>  |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 02 1998</b>  |  | 32. Registrar's Signature<br><b>John Davidson-Randall</b>   |  |   |  |   |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item: 7 per F.H G-758 4/28/98 reb

## Certificate of Death

Reg. No.

97 39923

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HOWARD EMERSON BUSH

2. Date of Death  
Month Day Year  
DECEMBER 20, 19973. Time of Death  
0835 AFuneral  
Director

4a. Facility Name (If not institution, give street and number)

FREDERICK MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

4c. County of Death

FREDERICK

5. Social Security Number

231-56-0363

6. Sex  
☒ M ☐ F

7. Age (In yrs. last birthday)

53 52 Yrs.

If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)

FEB. 28, 1945

9. Birthplace (State or Foreign  
Country)

HERNDON, VA.

Usual Residence of Decedent

10a. State

MD.

10b. County

FREDERICK

10c. City, Town or Location

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1212 TANEY AVENUE

10f. Zip Code

21702

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
BLACK15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
10

College (1-4 or 5+)

18a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

CUSTODIAN

16b. Kind of Business/Industry

FREDERICK CNTY. SCHOOLS

17. Father's Name (First, Middle, Last)

LOUIS ALBERT BUSH

18. Mother's Name (First, Middle, Maiden Surname)

VELMA COOPER

19a. Informant's Name/Relationship (Type, Print)

RUTH BUSH (SISTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

801 CRESTVIEW DRIVE, HERNDON, VA. 20170

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

MT. PLEASANT CHURCH CEMET. 12/27/97 HERNDON, VA.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

GREEN FUNERAL HOME, 721 ELDEN ST., HERNDON, VA.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
stroke, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. *Arteriosclerotic cardiovascular disease*  
Due to (or as a consequence of):b. \_\_\_\_\_  
Due to (or as a consequence of):c. \_\_\_\_\_  
Due to (or as a consequence of):d. \_\_\_\_\_  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

OCME

29d. Date signed (Month, Day, Year)

DECEMBER 21, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JAN 02 1998

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39924

|   |  |  |   |  |  |
|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>GEORGE BALIS</b>  |  | 2. Date of Death<br>Month <b>DECEMBER</b> Day <b>29</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>9:05AM</b>  |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>UNIVERSITY OF MARYLAND MEDICAL CENTER</b>   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death<br><b>N/A</b>  |
| Funeral<br>Director   | 5. Social Security Number<br><b>220-42-3290</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>68</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   |
|   | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 29, 1929</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Greece</b>   |  |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent  |  | 10c. City, Town or Location   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|   | 10e. State<br><b>Md.</b>   | 10b. County<br><b>Baltimore</b>  |   |  |  |
|   | 10e. Street and Number<br><b>1146 Gypsy Lane East</b>  |  | 10f. Zip Code<br><b>21286</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>College (1-4 or 5+) 5+</b>                        |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Professor of Psychiatry</b>   |
|   | 17. Father's Name (First, Middle, Last)<br><b>Ulysses Balis</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Angelica Yannakakis</b>   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Sophia Balis M.D./Wife</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1146 Gypsy Lane East Towson, Maryland 21204</b> |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. Demetrios Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>  |
|   | 21. Signature of Funeral Service Licensee<br><b>Michael P. Rudy</b>  |  | 22. Name and Address of Facility<br><b>Ruck Towson Funeral Home, Inc.<br/>1050 York Road Towson, Maryland 21204</b>                                 |  |  |
|   | 23e. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>a. ADENOCARCINOMA OF UNKNOWN PRIMARY</b><br>Due to (or as a consequence of):<br><b>b.</b> Due to (or as a consequence of):<br><b>c.</b> Due to (or as a consequence of):<br><b>d.</b> |  |   |  |  |
| 23f. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |  |   |  |  |
| 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28e. Date of Injury (Month, Day, Year)                                     |   | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28d. Describe how Injury occurred  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |
| 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |  |  |
| 29b. Signature and title of certifier<br><b>John (BORLUARE)</b>   |  | 29c. License number<br><b>P09727</b>                                       |   | 29d. Date signed (Month, Day, Year)<br><b>December 29, 1997</b>              |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>LEIGH EBONY BORLUARE, MD 22 SOUTH GREENE STREET, BALTIMORE, MARYLAND</b>   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 02 1998</b>   |  | 32. Registrar's Signature<br><b>Julia Davidson-Rendell</b>                 |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

18

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39925

|   |   |  |  |   |   |                                 |   |  |
|---|---|--|--|---|---|---------------------------------|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>MARY J BRAY</b>  |  |  |   | 2. Date of Death<br>Month <b>DEC.</b> Day <b>27</b> Year <b>1997</b>  |                                 | 3. Time of Death<br><b>12:24 PM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>University of Maryland</b>   |  |  |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |                                 | 4c. County of Death<br><b>N/A</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>411-44-0211</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>66</b> Yrs.  |                                 | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 7, 1931</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Tn.</b>  |  | 10a. State<br><b>Tn.</b>   |   | 10b. County<br><b>Shelby</b>  |                                 | 10c. City, Town or Location<br><b>Cordova</b>   |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   | 10e. Street and Number<br><b>8215 Walnut Grove Rd.</b>  |                                 | 10f. Zip Code<br><b>38018</b>   |  |
|   | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
|   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |                                 |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (14 or 5+) <b>College</b>  |  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Home maker</b>  |                                 |   |  |
|   | 16b. Kind of Business/Industry<br><b>Own home</b>   |  |  |   | 17. Father's Name (First, Middle, Last)<br><b>Floyd Brown, Sr.</b>  |                                 |   |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Feddy Lou Keltner</b>   |  |  |   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. Philip Bray/son</b>  |                                 |   |  |
|   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8663 Open Meadow Way Columbia, Md. 21045</b>  |  |  |   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |                                 |   |  |
|   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Forest Hill Cemetery</b>   |  |  |   | 20c. Location - City or Town, State<br><b>Memphis, Tn.</b>  |                                 | 20d. Date<br><b>12/31/97</b>  |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |  |   | 22. Name and Address of Facility<br><b>Ruck Towson Funeral Home, Inc.<br/>1050 York Rd. Towson, Md. 21204</b>   |                                 |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>SEPTIC SHOCK</b><br>Due to (or as a consequence of):<br><br>b. <b>GAS GANGRENE OF THE LOWER EXTREMITIES</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of): |  |  |   | Approximate Interval Between Onset and Death<br><br><b>12 HOURS</b><br><br><b>36 HOURS</b>  |                                 |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>DIABETES, HYPERTENSION</b><br><br><b>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</b>  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |                                 |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |                                 |   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |                                 |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   |  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b> |   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  | 28d. Describe how Injury occurred   |   |                                 |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |                                 |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |  | 29b. Signature and title of certifier<br><b>John A. Britten, MD</b>   |   |                                 |   |  |
| 29c. License number<br><b>D-22260</b>   |   |  |  | 29d. Date signed (Month, Day, Year)<br><b>12/27/97</b>  |   |                                 |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JOHN S. BRITTEN, 22 S. GRIZZARD STREET, BALTIMORE, MD 21201</b>  |   |  |  | 31. Date filed (Month, Day, Year)<br><b>JAN 02 1998</b>   |   |                                 |   |  |
| 32. Registrar's Signature<br>  |   |  |  | 33. State Registrar   |   |                                 |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39926

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ANDREW WILLIAM BALUCK

2. Date of Death

December 29, 1997

3. Time of Death

4:40 pm

4a. Facility Name (If not institution, give street and number)

Maryland General Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

154-12-7072

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

11-30-1919

9. Birthplace (State or Foreign Country)

Delaware

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

11 West 20th Street

10f. Zip Code

21218

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12 yr's

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Driver

16b. Kind of Business/Industry

Cab Company

17. Father's Name (First, Middle, Last)

William

Baluck

18. Mother's Name (First, Middle, Maiden Surname)

Helen

V.

Czelkevitch

19a. Informant's Name/Relationship (Type, Print)

Mrs. Veronica Fontana - Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

310 Westmoreland Ave. Wilmington, Delaware 19804

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oak Lawn Cemetery

Date

1/2/98

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Paul L. Hartsock, Jr.

22. Name and Address of Facility

Baltimore, Maryland 21214

Leonard J. Ruck, Inc. 5305 Harford Rd.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Pneumonia

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Cachexia

Due to (or as a consequence of):

Respiratory Failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Liaquat Ali

29c. License number

D47405

29d. Date signed (Month, Day, Year)

12/29/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Liaquat Ali, M.D. to Maryland General Hospital.

31. Date filed (Month, Day, Year)

JAN 02 1998

32. Registrar's Signature

John Davidson-Randall

State  
RegistrarAndrew Baluck  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



97 39927

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Halsey Chenoweth</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>12</b> DAY <b>31</b> YEAR <b>1997</b>   |  | 3. TIME OF DEATH<br><b>12:19 AM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>548-42-1433</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>63</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>1/4/1934</b>   |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>MARINER HEALTH OF NORTH ARUND.</b>  |  |  |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>GLEN BURNIE</b>  |  | 8c. BIRTHPLACE (State or Foreign Country)<br><b>CALIFORNIA</b>   |  |
| 9a. RESIDENCE OF DECEDENT  |  |  |  | 9b. COUNTY OF DEATH<br><b>ANNE ARUNDEL</b>   |  | 9c. COUNTY OF DEATH<br><b>ANNE ARUNDEL</b>   |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>ANNE ARUNDEL</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>PASADENA</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>8102 BEACHBERRY CT., APT. #1105</b>   |  |  |  | 10f. ZIP CODE<br><b>21122</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>KOREAN CONFLICT</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>5+</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>ENGINEER</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>RELIABILITY ENG.</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>TROY DONALD CHENOWETH</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARY EULLIS MAJOR</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>JOAN R. CHENOWETH</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8102 BEACHBERRY CT., #1105, PASADENA, MD 21122</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>METRO CREMATORY</b>  |  | 20c. DATE<br><b>12/31</b>  |  | 20d. LOCATION — City or Town, State<br><b>BALT., MD.</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>RAYMOND C. FINK FUNERAL HOME</b><br><b>426 CRAIN HWY., SW., GLEN BURNIE, MD 21061</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Lung Cancer</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Bruce S. Jindler, MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>027444</b>   |  | 29d. DATE SIGNED (Month/Day/Year)<br><b>12/31/97</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Bruce S. Jindler, MD 1314 Bedford Ave</b>  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JAN 02 1998</b>  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39928

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Christine

Caughlin

2. Date of Death

Month Day Year

December 28, 1997

3. Time of Death

1608

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

457-60-1605

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year

5/30/1924

9. Birthplace (State or Foreign Country)

GERMANY

Usual Residence of Decedent

10a. State

MD

10b. County

ANNE ARUNDEL

10c. City, Town or Location

GLEN BURNIE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

1007 DUNBARTON ROAD

10f. Zip Code

21061

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ARTIST

16b. Kind of Business/Industry

CRAFTS

17. Father's Name (First, Middle, Last)

GEORGE GLAUBITZ

18. Mother's Name (First, Middle, Maiden Surname)

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

MARY HARDY - DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3629 TURBRIGE DRIVE, BURDONSVILLE, MD 20866

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GLEN HAVEN MEM. PK.

Date

12/31

20c. Location - City or Town, State

GLEN BURNIE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

RAYMOND C. FINK FUNERAL HOME

426 CRAIN HWY., SW, GLEN BURNIE, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. small bowel obstruction

Due to (or as a consequence of):

2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. carcinomatosis

Due to (or as a consequence of):

2 days

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John MD

29c. License number

Res - 000

29d. Date signed (Month, Day, Year)

December 28, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Taylor Sohn MD The Johns Hopkins Hospital, Baltimore, MD

31. Date filed (Month, Day, Year)

JAN 02 1998

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

39929

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

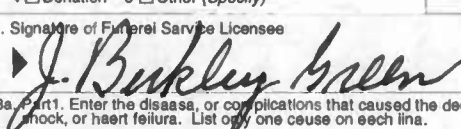
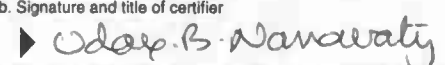
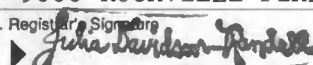
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |  |   |                                |  |  |
|--|--|---|--|---|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>RACHEL ELLEN CRANE</b>  |  |   |  | 2. Date of Death<br>Month <b>DECEMBER</b> Day <b>26</b> , Year <b>1997</b>  |                                | 3. Time of Death<br><b>5:30 PM</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>NATIONAL INSTITUTES OF HEALTH</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>BETHESDA</b>   |                                | 4c. County of Death<br><b>MONTGOMERY</b>   |  |
| 5. Social Security Number<br><b>224-25-7207</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>31</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>JUNE 24, 1966</b>                                    |  |
| 9. Birthplace (State or Foreign Country)<br><b>PEORIA, IL</b>  |  |   |  |   |                                |  |  |
| Usual Residence of Decedent  |  |   |  |   |                                |  |  |
| 10a. State<br><b>VA</b>  |  | 10b. County<br><b>FAIRFAX</b>   |  | 10c. City, Town or Location<br><b>MCLEAN</b>  |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>7624 BURFORD DR.</b>  |  |   |  | 10f. Zip Code<br><b>22102</b>   |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>MARKETING</b>   |                                | 16b. Kind of Business/Industry<br><b>FOOD CHAIN</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>PHILIP MILLER CRANE</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ARLENE CATHERINE JOHNSON</b>  |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>PHILIP M. CRANE</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7624 BURFORD DR., MCLEAN, VA 22102</b>  |                                |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ROSE HILL CEMETERY</b>   |  | Data<br><b>12/31/97</b>   |                                | 20c. Location - City or Town, State<br><b>HILLSBORO, IN</b>                                    |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>GREEN FUNERAL HOME, 721 ELDEN ST., HERNDON, VA 20170</b>   |                                |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>RESPIRATORY FAILURE</b><br>Due to (or as a consequence of):<br>b. <b>DISSEMINATED CANDIDIASIS</b><br>Due to (or as a consequence of):<br>c. <b>GRAFT VERSUS HOST DISEASE, LARGE BOWEL</b><br>Due to (or as a consequence of):<br>d. <b>NON HODGKINS LYMPHOMA</b> |  |   |  |   |                                |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |   |                                |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |   |                                |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |   |                                |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of injury<br>M  |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  |
| 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28d. Describe how injury occurred   |                                |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |                                |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |                                |  |  |
| 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br><b>051119</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>12-26-97</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>UDAY B. NANA VATY 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892</b>   |  |   |  |   |                                |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 02 1998</b>  |  |   |  | 32. Registrar's Signature<br>  |                                |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39930

|  |  |                          |   |  |  |                                |   |  |  |
|--|--|--------------------------|---|--|--|--------------------------------|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>George Clementoni  |                          |   |  | 2. Date of Death<br>Month Day Year<br>Dec, 30, 1997  |                                |   | 3. Time of Death<br>1150 am  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Johns Hopkins Bayview Medical Center |                          |   |  | 4b. City, Town, or Location of Death<br>Baltimore  |                                |   | 4c. County of Death<br>N/A   |  |
| Funeral<br>Director  | 5. Social Security Number<br>219-07-5488   |                          | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>76 Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br>April 25, 1921   |  | 9. Birthplace (State or Foreign Country)<br>Italy  |
|  | Usual Residence of Decedent  |                          |   |  |  |                                |   |  |  |
| 10a. State<br>Md.  |  | 10b. County<br>Baltimore |   | 10c. City, Town or Location<br>Dundalk   |  |                                |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br>3133 Cornwall Rd.  |  |                          |   |  | 10f. Zip Code<br>21222   |                                | 10g. Citizen of What Country?<br>USA  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |                          | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White                               |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 7 yrs.<br>Collega (1-4or 5+)  |  |                          |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>self employed |  |                                | 16b. Kind of Business/Industry<br>Painting  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Angelo Clementoni   |  |                          |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Adeline Esposito  |                                |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Brenda Alvarez daughter  |  |                          |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>208 Spring Maiden Ct. Glen Burnie Md. 21060   |                                |   |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |                          |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metro Crematory                                  |  | Date<br>1-2                    |   | 20c. Location - City or Town, State<br>Baltimore   |  |
| 21. Signature of Funeral Service Licensee<br>  |  |                          |   |  | 22. Name and Address of Facility<br>Connolly Funeral Home Of Dundalk<br>7110 Sollers Point Rd. 21222   |                                |   |  |  |
| 23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. Atherosclerotic coronary vascular disease<br>Due to (or as a consequence of):<br>years<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Cardiac dysrhythmia<br>Due to (or as a consequence of):<br>1.5 hr<br>c. myocardial ischemia<br>Due to (or as a consequence of):<br>1.5 hr<br>d. |  |                          |   |  |  |                                |   |  | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |                          |   |  |  |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |
|  |  |                          |   |  |  |                                | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |                          | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |                                |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  |                          | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |
|  |  |                          | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner  |  |                          | 16. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |                                |   |  |  |
| 29b. Signature and title of certifier<br>   |  |                          |   |  | 29c. License number<br>D28684  |                                | 29d. Date signed (Month, Day, Year)<br>1/11/98  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Edward S. Bestman, MD Bayview Medical Center Balto 21224   |  |                          |   |  |  |                                |   |  |  |
| 31. Date filed (Month, Day, Year)<br>JAN 02 1998   |  |                          |   |  |  |                                |   |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 39931

|   |   |  |   |  |  |   |   |  |
|---|---|--|---|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>DEBORAH DORM</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>DECEMBER 24, 1997</b>   |   | 3. Time of Death<br><b>8:15 a.m.</b>                                    |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Stella Maris Hospice</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Towson</b>  |   | 4c. County of Death<br><b>Baltimore</b>                                 |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-80-6884</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>36</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>July 17, 1961</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>N. Carolina</b>   |
|   | Usual Residence of Decedent   |  |   |  |  |   |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>N/A</b>  | 10c. City, Town or Location<br><b>Baltimore</b>   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No        |   |  |
|   | 10e. Street and Number<br><b>1039 N. Durham Street</b>  |  |   | 10f. Zip Code<br><b>21213</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th grade</b><br>College (14 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Correctional Officer</b>          |  | 16b. Kind of Business/Industry<br><b>State of Maryland</b>   |   |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>JAMES WALLACE</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>BESSIE E. AGNEW</b>  |  |   |   |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>JACOB AGNEW / Brother</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>219 W. 27th Street Baltimore, Md 21211</b> |  |   |   |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GREENMOUNT CREMATORY</b>   |  | Date<br><b>12-30-97</b>  | 20c. Location - City or Town, State<br><b>Baltimore, Md</b>   |   |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Larry Harris</b>  |  | 22. Name and Address of Facility<br><b>CHAARM - HARRIS P.H.<br/>5240 REISTERSTOWN ROAD<br/>BALTIMORE, MD 21215</b>                                |  |  |   |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Acute Immune Def Virus</b><br><b>b. Sepsis</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>c.</b><br><b>d.</b> |  |   |  |  |   |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |  |  |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b> |   |  |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No           |   | 28d. Describe how injury occurred  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><b>DR. PENELOPE EDWARDS</b>   |   | 29c. License number<br><b>D44128</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>12/24/97</b>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DR. PENELOPE EDWARDS 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093</b>  |   |  |   |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 02 1998</b>   |   | 32. Registrar's Signature<br><b>Jake Davidson-Randall</b>  |   |  |  |   |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39932

|  |   |  |  |  |   |   |                                |  |   |  |
|--|---|--|--|--|---|---|--------------------------------|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>EMMA J. EDWARDS</b>                            |  |  |  | 2. Date of Death<br>Month Day Year<br><b>Dec. 27 1997</b> |   |                                |  | 3. Time of Death<br><b>9:30 am</b>              |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>4112 Penhurst Avenue</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |   |                                |  | 4c. County of Death<br><b>NA</b>                |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>250-38-5089</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs.          |   | If Under 1 Year<br>Months Days |  | If Under 24 Hrs.<br>Hours Min.                  |  |
|  | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 1 1928</b>                                     |  | 9. Birthplace (State or Foreign Country)<br><b>S.C.</b>                    |  | 10a. State<br><b>MD</b>                                   |   | 10b. County<br><b>NA</b>       |  | 10c. City, Town or Location<br><b>Baltimore</b> |  |
| Usual Residence of Decedent  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>4112 Penhurst Avenue</b>  |   | 10f. Zip Code<br><b>21215</b>   |                                | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>   |                                | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b><br>College (1-4 or 5+) <b>5+</b>  |   |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Parent Liason</b>  |   | 16b. Kind of Business/Industry<br><b>Dept. of Education</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>William Jackson</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Louise Alston</b>   |                                | 19a. Informant's Name/Relationship (Type, Print)<br><b>Joseph L. Edwards Sr.-Husband</b>   |   |  |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4112 Penhurst Ave. Balto., Md 21215</b>                                    |   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garrison Forest Vet. Cem. 1-2-98</b>  |   | 20c. Location - City or Town, State<br><b>Owings Mills, Md</b>  |                                | 21. Signature of Funeral Service Licensee<br><b>Phyllis B. Harris</b>  |   |  |
| 22. Name and Address of Facility<br><b>Wm. C. March Funeral Home West, Inc.<br/>4300 Wabash Av. Balto., Md 21215</b>   |   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Pulmonary Embolus</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d.</b> |  | Approximate Interval Between Onset and Death<br><b>subh</b>  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |                                | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Renal Failure. After weeks of Heart Disease</b>   |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |   |  |
| 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred   |                                | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br><b>Dr. Robert Levy</b>  |   | 29c. License number<br><b>D09212</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>12/29/97</b>   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Robert Levy 1838 Greentree Suite 245 Balto, Md 21208</b>                        |   | 31. Date filed (Month, Day, Year)<br><b>JAN 02 1998</b>  |  | 32. Registrar's Signature<br><b>John Davidson-Randall</b>  |   | 33. Date of filing (Month, Day, Year)   |                                | 34. Registrar's Title  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68766

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39933

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HILDA C ELLIS

2. Date of Death

Month

Day

Year

DECEMBER

22

97

3. Time of Death

2012

4a. Facility Name (If not institution, give street and number)

SINAI HOSPITAL OF BALTIMORE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NA

Funeral  
Director

5. Social Security Number

217-24-2040

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

MAR. 31 1930

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4123 GRANADA AVE.

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

7th

College (1-4or 5+)

NA

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Custodian

18b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Charles P. Clay

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Chase

19a. Informant's Name/Relationship (Type, Print)

MAURICE ELLIS - SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4123 GRANADA AVE. BALTO. MD. 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

WOODLAWN CEMETERY 12-27-97 BALTO. MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Blynn B. Harris

22. Name and Address of Facility

March Funeral Home - West  
4300 Wabash Ave. BALTO. MD. 2121523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. CORONARY ARTERY DISEASE  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

10 YRS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

SWOON SINAI MD

29c. License number

DS1804

29d. Date signed (Month, Day, Year)

DECEMBER 22, 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SWOON SINAI HOSPITAL OF BALTIMORE

BALTIMORE MD 21215

31. Date filed (Month, Day, Year)

JAN 02 1998

32. Registrar's Signature

Felia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item: 20b Per FH Film G-754 1-2-98RC

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39934

|   |  |   |   |   |  |  |  |  |   |   |                           |   |  |                                     |  |                                     |  |                                     |  |  |  |
|---|--|---|---|---|--|--|--|--|---|---|---------------------------|---|--|-------------------------------------|--|-------------------------------------|--|-------------------------------------|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>CATHRYNE A. EVERETT</b>               |   |   |   |  |  | 2. Date of Death<br>Month Day Year<br><b>December 26, 1997</b>                       |  | 3. Time of Death<br><b>11:05 PM</b>                         |   |                           |   |  |                                     |  |                                     |  |                                     |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Pickersgill</b> |   |   |   |  |  | 4b. City, Town, or Location of Death<br><b>Towson</b>                                |  | 4c. County of Death<br><b>Baltimore County</b>              |   |                           |   |  |                                     |  |                                     |  |                                     |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>218-32-6627</b>                                      |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>95</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 17, 1902</b>                          |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |   |                           |   |  |                                     |  |                                     |  |                                     |  |  |  |
|   | Usual Residence of Decedent  |   |   |   |  |  |  |  |   |   |                           |   |  |                                     |  |                                     |  |                                     |  |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore County</b>                        |   | 10c. City, Town or Location<br><b>Towson</b>  |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |                           |   |  |                                     |  |                                     |  |                                     |  |  |  |
| 10e. Street and Number<br><b>615 Chestnut Avenue</b>  |  |   |   | 10f. Zip Code<br><b>21204</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |   |   |                           |   |  |                                     |  |                                     |  |                                     |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |   |                           |   |  |                                     |  |                                     |  |                                     |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  |   |   | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary</b> |  |  | 16b. Kind of Business/Industry<br><b>Banking</b>                                     |  |   |   |                           |   |  |                                     |  |                                     |  |                                     |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Francis H. Ahl</b>  |  |   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Nellie Schuler</b>   |  |  |   |   |                           |   |  |                                     |  |                                     |  |                                     |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Thomas H. Everett, Jr. (Son)</b>   |  |   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4 Candlelight Court, Lutherville, MD 21093</b> |  |  |   |   |                           |   |  |                                     |  |                                     |  |                                     |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parkwood Cemetery</b>  |   |  | 20c. Location - City or Town, State<br><b>1-5-98</b><br><b>1/5/97</b> <b>Parkville, Maryland</b>   |  |  |   |   |                           |   |  |                                     |  |                                     |  |                                     |  |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Martin D. Dawson</b>  |  |   |   |   |  | 22. Name and Address of Facility<br><b>Mitchell-Wiedefeld Home</b><br><b>6500 York Road, Baltimore, Maryland 21212</b>                             |  |  |   |   |                           |   |  |                                     |  |                                     |  |                                     |  |  |  |
| 23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |   |   |  |  |  |  |   |   |                           |   |  |                                     |  |                                     |  |                                     |  |  |  |
| <table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>acute pneumonia</b></td> <td>Approximate Interval Between Onset and Death<br/><b>5 days</b></td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td></td> <td></td> </tr> </table> |  |   |   |   |  |  |  |  |   | Immediate Cause (Final disease or condition resulting in death) | a. <b>acute pneumonia</b> | Approximate Interval Between Onset and Death<br><b>5 days</b> | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): |  | c. Due to (or as a consequence of): |  | d. Due to (or as a consequence of): |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)   | a. <b>acute pneumonia</b>  | Approximate Interval Between Onset and Death<br><b>5 days</b> |   |   |  |  |  |  |   |   |                           |   |  |                                     |  |                                     |  |                                     |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | b. Due to (or as a consequence of):  |   |   |   |  |  |  |  |   |   |                           |   |  |                                     |  |                                     |  |                                     |  |  |  |
|   | c. Due to (or as a consequence of):  |   |   |   |  |  |  |  |   |   |                           |   |  |                                     |  |                                     |  |                                     |  |  |  |
|   | d. Due to (or as a consequence of):  |   |   |   |  |  |  |  |   |   |                           |   |  |                                     |  |                                     |  |                                     |  |  |  |
|   |  |   |   |   |  |  |  |  |   |   |                           |   |  |                                     |  |                                     |  |                                     |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>severe dementia</b>  |  |   |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |   |                           |   |  |                                     |  |                                     |  |                                     |  |  |  |
|   |  |   |   |   |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |                           |   |  |                                     |  |                                     |  |                                     |  |  |  |
|   |  |   |   |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |   |                           |   |  |                                     |  |                                     |  |                                     |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |   |   |                           |   |  |                                     |  |                                     |  |                                     |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred                           |   |                           |   |  |                                     |  |                                     |  |                                     |  |  |  |
|   |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |  |   |   |                           |   |  |                                     |  |                                     |  |                                     |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |   |   |  |  |  |  |   |   |                           |   |  |                                     |  |                                     |  |                                     |  |  |  |
| 29b. Signature and title of certifier<br><b>H. Anthony Riley, M.D.</b>  |  |   |   |   |  | 29c. License number<br><b>D25205</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>December 30, 1997</b>  |   |   |                           |   |  |                                     |  |                                     |  |                                     |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>W. Anthony Riley, M.D., GBMC East Pavillion, Suite 203, Towson, MD 21204</b>   |  |   |   |   |  |  |  |  |   |   |                           |   |  |                                     |  |                                     |  |                                     |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 02 1998</b>   |  |   | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>  |   |  |  |  |  |   |   |                           |   |  |                                     |  |                                     |  |                                     |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

07 39935

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James Grey Fennell Jr.

2. Date of Death  
Month Day Year

December 28, 1997

3. Time of Death

2248

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

238-26-5333

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

Mar. 11, 1923

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Gambrills

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2324 Mt. Tabor Road

10f. Zip Code

21054

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CW04

16b. Kind of Business/Industry

US AirForce

17. Father's Name (First, Middle, Last)

James Grey Fennell Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

James G. Fennell - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2334 Mt. Tabor Road, Gambrills, MD 21054

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

12/30

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Batack A. Gendall

22. Name and Address of Facility

Hardesty Funeral Home, P.A.  
12 Ridgely Ave. Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Probable MI

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Unknown

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

30'

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

K.S. Gummerson

29c. License number

D24336

29d. Date signed (Month, Day, Year)

December 30, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K.S. Gummerson, Annapolis, MD 21401

31. Date filed (Month, Day, Year)

JAN 02 1998

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39936

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be submitted within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><u>Coleen Fisher</u>   |  |  |  | 2. Date of Death<br>Month <u>12</u> Day <u>28</u> Year <u>97</u>   |  | 3. Time of Death<br><u>1:22 PM</u>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><u>Bon Secours Hospital</u>  |  |  |  | 4b. City, Town, or Location of Death<br><u>Balto, MD</u>   |  | 4c. County of Death<br><u>N/A</u>  |  |
| 5. Social Security Number<br><u>214-56-7057</u>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><u>46</u> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><u>Apr. 26, 1951</u>                                    |  |
| 9. Birthplace (State or Foreign Country)<br><u>MD</u>  |  |  |  | 10. Usual Residence of Decedent  |  |  |  |
| 10a. State<br><u>MD</u>  |  | 10b. County<br><u>N/A</u>  |  | 10c. City, Town or Location<br><u>Baltimore</u>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><u>1301 Division Street</u>  |  |  |  | 10f. Zip Code<br><u>21217</u>  |  | 10g. Citizen of What Country?<br><u>USA</u>  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>Black</u>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>10th Grade</u><br>Collage (1-4or 5+) <u></u>   |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Dancer</u>   |  | 16b. Kind of Business/Industry<br><u>Self-Employed</u>   |  |
| 17. Father's Name (First, Middle, Last)<br><u>James Dorsey</u>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Catherine Dorsey</u>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>Valerie White - Sister</u>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>508 N. Gilmore St., Balto, MD 21223</u>  |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Metro Cemetary</u>  |  | 20c. Location - City or Town, State<br><u>12/29/97 Balto., MD</u>  |  | 20d. Date  |  |
| 21. Signature of Funeral Service Licensee<br><u>Willie E. Howell Jr.</u>   |  |  |  | 22. Name and Address of Facility<br><u>Unity Funeral Home - 108 W. North Av. Baltimore, MD 21201 - (410) 752-4941</u>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><u>CARDIOPULMONARY ARREST</u><br>Due to (or as a consequence of):<br><u>DISSEMINATED INTRAVASCULAR COAGULATION</u><br>Due to (or as a consequence of):<br><u>SEPSIS</u><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Approximate Interval Between Onset and Death |  |  |  |  |  |  |  |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |  |  |
| 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |  |  |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)<br><u></u>  |  | 28b. Time of Injury<br><u>M</u>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28d. Describe how injury occurred  |  |  |  |
| 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br><u>[Signature] MD</u>   |  |  |  | 29c. License number<br><u>D46529</u>   |  | 29d. Date signed (Month, Day, Year)<br><u>12-23-97</u>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>2000 W Baltimore ST.</u>  |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)  |  |  |  | 32. Registrar's Signature  |  |  |  |

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39937

|   |   |  |   |   |  |  |   |   |
|---|---|--|---|---|--|--|---|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>CYNTHIA GRAY</b>   |  |   |   | 2. Date of Death<br>Month <b>DECEMBER</b> Day <b>26</b> Year <b>97</b>   |  | 3. Time of Death<br><b>7:10PM</b>                                       |   |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>NORTHWEST HOSPITAL</b>   |  |   |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>Baltimore</b>                                 |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-50-3570</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>50</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>FEB 13 1947</b>               | 9. Birthplace (State or Foreign Country)<br><b>N.C.</b>   |
|   | Usual Residence of Decedent   |  |   |   |  |  |   |   |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>   | 10b. County<br><b>NA</b>                           | 10c. City, Town or Location<br><b>Baltimore</b>   |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |   |
|   | 10e. Street and Number<br><b>616 Springfield Ave.</b>   |  |   |   | 10f. Zip Code<br><b>21212</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                             |   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b>  |  | College (1-4 or 5+) <b>4 yrs</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Sales Director</b>   |  | 16b. Kind of Business/Industry<br><b>Mary Kay</b>                       |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>Kemp McCoy</b>  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Altesia Burney</b>   |  |   |   |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>John A. Gray - Husband</b>   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>616 Springfield Ave. Balto. Md 21212</b>   |  |   |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Woodlawn Cemetery</b>  |   | Date<br><b>1-2-98</b>  |  | 20c. Location - City or Town, State<br><b>Balto. Md</b>                 |   |
|   | 21. Signature of Funeral Service Licensee<br><b>Phyllis B. Stans</b>  |  |   |   | 22. Name and Address of Facility<br><b>Wm. C. March Funeral Home West Inc<br/>4300 Wabash Ave. Balto. Md 21215</b>   |  |   |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>PNEUMOTHORAX</b><br>Due to (or as a consequence of):<br><b>BILATERAL PLEURAL EFFUSION</b><br>Due to (or as a consequence of):<br><b>CARCINOMA BREAST</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |  |   |   |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |   |  |  |   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |   |   |  |  |   |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)             |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   | 28d. Describe how injury occurred                         |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><b>MD</b> |   | 29c. License number<br><b>BG 4439128</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>DECEMBER 26 1997</b>                                 |   |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>THOMAS GEORGE CENTER, 5401 OLD COURT ROAD, RANDALLSTOWN, 21133</b>   |   |  |   | 31. Date filed (Month, Day, Year)<br><b>JAN 02 1998</b>   |  |  |   | 32. Registrar's Signature<br><b>John Harrison Randall</b> |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68788

State Registrar



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Item: 20b Per FH Film G-754 1-2-98RC State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39938

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Paul Kenneth Gross

2. Date of Death  
Month Day Year  
DECEMBER 26, 19973. Time of Death  
10:13 PFuneral  
Director

4a. Facility Name (If not institution, give street and number)

1210 SILVERTHORNE RD.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

214-50-3237

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

50

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

11-19-47

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1210 Silverthorne Road

10f. Zip Code

21239

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 6-30-65  
5/31/68

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Data Entry Operator

16b. Kind of Business/Industry

Social Security Admin.

17. Father's Name (First, Middle, Last)

Louis Allen Gross

18. Mother's Name (First, Middle, Maiden Surname)

Aretta Hurd

19a. Informant's Name/Relationship (Type, Print)

Carolyn Collins-sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5511 Sagra Road Baltimore, MD 21239

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest VA Cem.

1-2-98

1-2-97

20c. Location - City or Town, State

Owings Mills, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

March Funeral Home-West 4300 Wabash Ave.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Hypertensive Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

INSPECTION

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

OCME

29d. Date signed (Month, Day, Year)

DECEMBER 27, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JAN 02 1998

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39939

|   |  |   |   |   |  |  |   |  |
|---|--|---|---|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Lillie A. Grimley</b>   |   |   |   | 2. Date of Death<br>Month <b>December</b> Day <b>30</b> , Year <b>1997</b>   |  | 3. Time of Death<br><b>1525</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Anne Arundel Medical Center</b>   |   |   |   | 4b. City, Town, or Location of Death<br><b>Annapolis</b>   |  | 4c. County of Death<br><b>Anne Arundel</b>                              |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>577-42-9904</b>  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>May 13, 1916</b>              |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   | 10a. State<br><b>MD</b>   |   | 10b. County<br><b>Anne Arundel</b>   |  | 10c. City, Town or Location<br><b>Edgewater</b>                         |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br><b>810 Shore Drive</b>  |   | 10f. Zip Code<br><b>21037</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                             |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                         |   | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Joseph H. Wilson</b>   |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lillie Nightingale</b>   |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Eugene W. Grimley - Grandson</b>  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>20659 26729 Yowaiski Mill Rd. Mechanicsville, MD</b>  |  |   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cemetery</b>  |   | 20c. Location - City or Town, State<br><b>1/3 Suitland, MD</b>   |  |   |  |
|   | 21. Signature of Funeral Service Licensee<br>  |   | 22. Name and Address of Facility<br><b>Hardesty Funeral Home, P.A.<br/>12 Ridgely Ave. Annapolis, MD 21401</b>  |   |  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Septic Shock</b><br>Due to (or as a consequence of):<br>b. <b>Cellulitis R leg</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><div style="position: absolute; left: 300px; top: 550px; font-size: 4em;">{</div> |   |   |   |  |  |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>COPD</b><br><b>Right Heart Failure</b>  |   |   |   |  |  |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |   |   |   |  |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |   |   |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |   |   |  |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>                                 |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |
| 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |   |  |  |   |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D38563</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>December 31, 1997</b> |  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Wayne P. Bickbaum 134 Owensville Road West River MD</b>  |  |   |   |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 02 1998</b>   |  | 32. Registrar's Signature<br>  |   |   |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

IRENE C HAMLIN

2. Date of Death

December 27<sup>th</sup> 1997

3. Time of Death

10:35 PM

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

5. Social Security Number

230-03-3863

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 12, 1920

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6800 Brompton Road

10f. Zip Code

21207

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

2 yrs.

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Billing Service Worker

16b. Kind of Business/Industry

Balto. Co. Schools

17. Father's Name (First, Middle, Last)

Robert Carter

18. Mother's Name (First, Middle, Maiden Surname)

Betty Penn

19a. Informant's Name/Relationship (Type, Print)

Kenneth Hamlin - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6800 Brompton Rd. Balto. Md 21207

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garden of Faith

Date

1-3-98 White Marsh, Md

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Shyrus B. Harris

22. Name and Address of Facility

Wm C. March Funeral Home West Inc. 4300 Wabash Ave. Balto. Md. 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Possible Aspiration Pneumonia

Due to (or as a consequence of):

b. cerebro vascular accident

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

non insulin dependent Diabetes

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending Investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Shresh K. Tripathi

29c. License number

D 30661

29d. Date signed (Month, Day, Year)

December 29<sup>th</sup> 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5670 The Alameda, Baltimore, Md - 21239

31. Date filed (Month, Day, Year)

JAN 02 1998

32. Registrar's signature

Jane Davidson-Randall

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39941

|                                     |  |  |   |  |  |  |  |  |
|-------------------------------------|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Elizabeth A. Holmes  |  |   |  | 2. Date of Death<br>Month Day Year<br>Dec 20, 1997   |  | 3. Time of Death<br>2301   |  |
|                                     | 4a. Facility Name (If not institution, give street and number)<br>Union Memorial Hospital Extended Care  |  |   |  | 4b. City, Town, or Location of Death<br>Baltimore  |  | 4c. County of Death<br>N/A   |  |
| Funeral<br>Director                 | 5. Social Security Number<br>218-01-1585   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>78 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Feb. 9, 1919                                  |  |
|                                     | 9. Birthplace (State or Foreign Country)<br>Maryland   |  | 10a. State<br>Maryland  |  | 10b. County<br>N/A   |  | 10c. City, Town or Location<br>Baltimore   |  |
| To Be Completed by Funeral Director | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 10e. Street and Number<br>501 West University Parkway   |  | 10f. Zip Code<br>21210   |  | 10g. Citizen of What Country?<br>U.S.A   |  |
|                                     | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |  |
|                                     | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 2   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Home Maker   |  | 16b. Kind of Business/Industry<br>Own Home   |  |  |  |
|                                     | 17. Father's Name (First, Middle, Last)<br>Peter J. Kestranek  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Elizabeth Koricki   |  |  |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br>Peter Holmes (Son)   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>501 West University Parkway, Baltimore, Md 21210  |  |  |  |
|                                     | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Gardens of Faith Cem.   |  | 20c. Location - City or Town, State<br>12/23/97 Rosedale, Maryland   |  |  |  |
|                                     | 21. Signature of Funeral Service Licensee<br>A. Alan Seitz, Jr.  |  |   |  | 22. Name and Address of Facility<br>A. Alan Seitz, Jr. Funeral Home<br>3818 Roland Avenue, Baltimore, Maryland 21211   |  |  |  |
|                                     | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Cardiac Arrest<br>Due to (or as a consequence of):<br>b. Atherosclerotic Cardiovascular Disease<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  |  |
|                                     | Approximate Interval Between Onset and Death<br>40 min<br>5 years  |  |   |  |  |  |  |  |
|                                     | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.<br>Laryngeal carcinoma, COPD,<br>History of CHF   |  |   |  |  |  |  |  |
| Physician<br>/Medical<br>Examiner   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |
|                                     | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |  |  |  |  |
|                                     | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
|                                     | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|                                     | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
|                                     | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |  |  |
|                                     | 29b. Signature and title of certifier<br>Paula Wolf Rosenthal MD   |  |   |  | 29c. License number<br>D31025  |  | 29d. Date signed (Month, Day, Year)<br>1/2/98  |  |
|                                     | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Carlo Wolf Rosenthal, MD, 3333 N. Calvert St #325, Baltimore MD 21218  |  |   |  |  |  |  |  |
|                                     | 31. Date filed (Month, Day, Year)<br>JAN 02 1998   |  |   |  | 32. Registrar's Signature<br>John Davidson   |  |  |  |



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

87 39942

|  |  |   |  |  |  |  |  |   |
|--|--|---|--|--|--|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>CHARLES ARNOLD HENSCHEN</b>                           |   |  |  | 2. Date of Death<br>Month Day Year<br><b>DECEMBER 27, 1997</b> |  | 3. Time of Death<br><b>3:05 AM</b>   |   |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>Saint Joseph Medical Center</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Towson</b>          |  | 4c. County of Death<br><b>Baltimore</b>  |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>219-03-6849</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs.   | If Under 1 Year<br>Months Days                                 | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 22 1923</b>                                     | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
|  | Usual Residence of Decedent  |   |  |  |  |  |  |   |
| 10a. State<br><b>MD.</b>   |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Lutherville</b>  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
| 10e. Street and Number<br><b>10 Margate Rd.</b>  |  |   |  | 10f. Zip Code<br><b>21093</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Management</b>   |  | 16b. Kind of Business/Industry<br><b>Retail/Service</b>  |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Charles E. Henschen</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lizetta Vollerthum</b>   |  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Shirley Henschen/Wife</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10 Margate Rd. Lutherville, MD. 21093</b>  |  |  |  |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hilltop Service Co.</b>  |  | Date<br><b>12-29-97</b>  |  | 20c. Location - City or Town, State<br><b>Towson, MD.</b>  |  |   |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Ruck Towson Funeral Home, Inc.<br/>1050 York Rd. Towson, MD. 21204</b>  |  |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>HEPATIC ENCEPHALOPATHY</b><br>Due to (or as a consequence of):<br><b>RENAL FAILURE</b><br>Due to (or as a consequence of):<br><b>CIRRHOSIS, DIABETES MELLITUS TYPE II</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>DAYS</b> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |
|  |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |
|  |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how Injury occurred                           |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |  |  |   |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D 41410</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>December 27th, 1997</b>  |  |  |  |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>JOGINDER P. MEHTA ST. JOSEPH MEDICAL CENTER TOWSON, MD.</b>   |  |   |  |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>DEC 30 1997</b>  |  | 32. Registrar's Signature<br>   |  |  |  |  |  |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Registrar

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

George C. Hartman

2. Date of Death

Month Day Year  
Dec. 29, 1997

3. Time of Death

1:30pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

213-09-1478

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 27, 1915

9. Birthplace (State or Foreign Country)

Pa.

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2512 Yorkway

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10 yrs.

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Beth. Steel

17. Father's Name (First, Middle, Last)

John Hartman

18. Mother's Name (First, Middle, Maiden Surname)

Regina Schobel

19a. Informant's Name/Relationship (Type, Print)

Gary Hartman son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1510 Raybille Rd. Parkton Md. 21120

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oaklawn Cem.

Date

12-31

20c. Location - City or Town, State

Baltimore

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Connelly Funeral Home Of Dundalk

7110 Sollers Point Rd. 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

1 hour

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary Artery Disease

Due to (or as a consequence of):

Unknown

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial fibrillation

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☒ Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Homicide ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D36430

29d. Date signed (Month, Day, Year)

12/31/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeffrey McArthurson, MD 2112 Dundalk Ave., Baltimore 21222

31. Date filed (Month, Day, Year)

JAN 02 1998

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



97 39944

DHH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39945

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Henry Edward Jones, Sr.

2. Date of Death

Month Day Year  
December 31, 1997

3. Time of Death

7:41 pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

5. Social Security Number

578-09-8498

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 16, 1921

9. Birthplace (State or Foreign Country)

Illinois

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

714 Montfrey Avenue

10f. Zip Code

21401

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (14 or 5+)  
616a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Dentist

16b. Kind of Business/Industry

Dentistry

17. Father's Name (First, Middle, Last)

William Hayes Jones

18. Mother's Name (First, Middle, Maiden Surname)

Amalia Salomonson

19a. Informant's Name/Relationship (Type, Print)

Florence Jones - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

714 Montfrey Avenue, Annapolis, MD 21401

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Saint Anne's Cemetery

Date

1/3/98

20c. Location - City or Town, State

Annapolis, MD

21. Signature of Funeral Service Licensee

Patrick J. Arnold

22. Name and Address of Facility

Hardesty Funeral Home, P.A.  
12 Ridgely Avenue, Annapolis, MD 2140123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Septic Shock

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

2 days

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter underlying  
cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Enterococcus urinary infection

Due to (or as a consequence of):

2 days

c. Renal Failure

Due to (or as a consequence of):

Yrs

d. Multiorgan Failure

2 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery disease - S/P MI

Marked left Ventricular failure

Generalized atherosclerosis - D.M.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
injury28c. Injury at  
Work?  
☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Joseph N. Friend MD

29c. License number

D17965

29d. Date signed (Month, Day, Year)

12/31/97

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Joseph N. Friend 205 Ridgely Ave Annapolis, MD 21401

31. Date filed (Month, Day, Year)

JAN 02 1998

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 39946

|   |  |  |   |  |   |  |  |  |
|---|--|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><i>Napoleon Jones</i>  |  |   |  | 2. Date of Death<br>Month <i>12</i> Day <i>31</i> Year <i>97</i>  |  | 3. Time of Death<br><i>9 57 pm</i>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><i>Maryland General Hospital</i>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  | 4c. County of Death<br><b>n/a</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>227-42-2121</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>65</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 8, 1932</b>   |  |
|   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>n/a</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| To Be Completed by Funeral Director           | 10e. Street and Number<br><b>1510 Mosher St.</b>   |  |   |  | 10f. Zip Code<br><b>21217</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Elevator Operator</b>   |  | 16b. Kind of Business/Industry<br><b>Factory</b>   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Bernard Jones</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Clara Robertson</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Trenia Jones/ niece</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1310 Woodbourne Ave. Balto., MD 21239</b>   |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>King Memorial Park</b>   |  | 20c. Location - City or Town, State<br><b>1/5 Randallstown, Md</b>  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><i>James A. Morton</i>  |  |   |  | 22. Name and Address of Facility<br><b>James A. Morton &amp; Sons Funeral Home<br/>1701 Laurens St. Baltimore, MD 21217</b>   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>a. <i>Respiratory Failure</i><br>Due to (or as a consequence of):<br><br>b. <i>Lung Cancer</i><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d. |  |   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|   |  |  |   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28d. Describe how injury occurred   |  |  |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |   |  |  |  |
|   | 29b. Signature and title of certifier<br><i>Ali Hiyazi Medical intern</i>  |  |   |  | 29c. License number<br><b>09502A</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>12/31/97</b>   |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DR. Ali Hiyazi<br/>827 Linden Ave. Balto MD 21201</b>   |  |   |  |   |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br><b>JAN 02 1998</b>  |  |   |  | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>  |  |  |  |

[Faint, illegible text covering the majority of the page, possibly bleed-through from the reverse side.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39947

|   |  |                                    |   |  |  |  |   |  |
|---|--|------------------------------------|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>RONALD JEROME</b>   |                                    |   |  | 2. Date of Death<br>Month Day Year<br><b>December 26, 1997</b>   |  | 3. Time of Death<br><b>11:30p.m.</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Stella Maris Hospice</b>  |                                    |   |  | 4b. City, Town, or Location of Death<br><b>Towson</b>  |  | 4c. County of Death<br><b>Baltimore</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>213-36-6684</b>  |                                    | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>57</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 20, 1940</b>                                 | 9. Birthplace (State or Foreign Country)<br><b>Md.</b> |
|   | Usual Residence of Decedent  |                                    |   |  |  |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Md.</b>   | 10b. County<br><b>Anna Arundel</b> | 10c. City, Town or Location<br><b>Glen Burnie</b>   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
|   | 10e. Street and Number<br><b>302 Blue Water Ct. Unit 204</b>   |                                    |   |  | 10f. Zip Code<br><b>21060</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |                                    | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 yrs.</b><br>College (1-4 or 5+) <b>4 yrs.</b>   |                                    | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>management</b>  |  | 16b. Kind of Business/Industry<br><b>Consulting Firm</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner   | 17. Father's Name (First, Middle, Last)<br><b>Lee James Jerome</b>   |                                    |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Catherine Znamkowski</b>   |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Betty Jerome wife</b>   |                                    |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>302 Blue Water Ct. Glen Burnie Md. 21060</b>   |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |                                    | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Sacred Heart of Jesus 12-31 Dundalk</b>  |  | 20c. Location - City or Town, State  |  | Approximate Interval Between Onset and Death  |  |
|   | 21. Signature of Funeral Service Licensese<br>   |                                    | 22. Name and Address of Facility<br><b>Connelly Funeral Home Of Dundalk<br/>7110 Sollers Point Rd. 21222</b>  |  |  |  |   |  |
| Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Metastatic Bladder Cancer</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b.</b> Due to (or as a consequence of):<br><b>c.</b> Due to (or as a consequence of):<br><b>d.</b> |                                    |   |  |  |  |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |                                    |   |  |  |  |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |                                    |   |  |  |  |   |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                                    |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                                    | 28. Place of Death (Check only one)<br>Hospice: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b> |  |  |  |   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |                                    | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |                                    | 28d. Describe how injury occurred   |  |  |  |   |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |                                    |   |  |  |  |   |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.<br>Important: If item 27 is marked other than "natural" or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once. | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |                                    |   |  |  |  |   |  |
|   | 29b. Signature and title of certifier<br>   |                                    |   |  | 29c. License number<br><b>044128</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>12-29-97</b>                                      |  |
|   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>DR. PENELOPE EDWARDS, 2300 DULANEY VALLEY RD., TIMONIUM, MD 21093</b>   |                                    |   |  |  |  |   |  |
|   | 31. Date filed (Month, Day, Year)<br><b>JAN 02 1998</b>  |                                    |   |  | 32. Registrar's Signature<br>   |  |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item 5 Per PH Film G755 1-16-98 rja

## Certificate of Death

Reg. No.

97 39948

|  |   |   |   |   |  |   |  |
|--|---|---|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Anna M Kirby</b>   |   |   | 2. Date of Death<br>Month <b>12</b> Day <b>30</b> Year <b>97</b>  |  | 3. Time of Death<br><b>7:50 PM</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>OAK CREST VILLAGE PRELUDICK WALKS</b>  |   |   | 4b. City, Town, or Location of Death<br><b>Parkville</b>  |  | 4c. County of Death<br><b>Baltimore</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-58-3330</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>96</b> Yrs.  | If Under 1 Year<br>Months   | If Under 24 Hrs.<br>Hours  | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 10, 1901</b>   | 9. Birthplace (State or Foreign Country)<br><b>Germany</b>   |
|  | Usual Residence of Decedent   |   |   |   |  |   |  |
| To Be Completed by Funeral Director  | 10e. State<br><b>Maryland</b>   | 10b. County<br><b>Baltimore</b>   | 10c. City, Town or Location<br><b>Baltimore</b>   |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  | 10a. Street and Number<br><b>8830 Walther Boulevard</b>   |   |   | 10f. Zip Code<br><b>21234</b>   |  | 10g. Citizen of What Country?<br><b>U. S. A.</b>  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th Grade</b>   |   | College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |   | 16b. Kind of Business/Industry<br><b>Own Home</b>  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Joseph Roth</b>   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anna Rib</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>William Kirby (Son)</b>  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8301 Alston Road, Baltimore, Maryland 21204</b> |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Most Holy Redeemer</b>   |   | Date<br><b>1/3/98</b>  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>   |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Brian J. Lewis</b>  |   |   | 22. Name and Address of Facility<br><b>Schmunek Funeral Home Inc.<br/>3331 Brehms Lane, Baltimore, Maryland 21213</b>                               |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. congestive heart failure</b><br>Due to (or as a consequence of):<br><b>b. coronary artery disease</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |   |  |   | Approximate Interval Between Onset and Death<br><b>immediate</b><br><br><b>years</b>   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |   |   | 28d. Describe how injury occurred   |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |   |   |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |   |  |   |  |
| 29b. Signature and title of certifier<br><b>Samuel C. Durso, MD</b>  |   |   | 29c. License number<br><b>047040</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>12 31 97</b>   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Samuel C. Durso, MD 8800 Walther Blvd, Parkville, MD 21234</b>  |   |   |   |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 02 1998</b>  |   | 32. Registrar's Signature<br><b>John Davidson-Randall</b>   |   |   |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1970 11 11 1970 11 11 1970 11 11

• • •

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39949

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William Kizman

2. Date of Death

Month  
12Day  
31Year  
97

3. Time of Death

0047

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

216-20-3705

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Oct. 4, 1925

9. Birthplace (State or Foreign Country)

PA.

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

3438 Logan View Dr.

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☒ Yes ☐ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12 yrs.

College (1-4 or 5+)

2 yrs.

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

General Foreman

16b. Kind of Business/Industry

Beth. steel

17. Father's Name (First, Middle, Last)

Paul Kizman

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Strauss

19a. Informant's Name/Relationship (Type, Print)

Grace Kizman wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3438 Logan View Dr. Dundalk Md. 21222

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Oak Lawn Cem.

Date

1-3

20c. Location - City or Town, State

Baltimore

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Connelly Funeral Home Of Dundalk  
7110 Sollers Point Rd. 2122223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)e. Myocardial Infarction  
Due to (or as a consequence of):b. Heart Disease  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

1/2 hour

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural  
☐ Accident  
☐ Suicide  
☐ Homicide☐ Pending  
Investigation  
☐ Could not be  
determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☐ No28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Eugene Kennedy MD

29c. License number

N5439

29d. Date signed (Month, Day, Year)

12/31/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Eugene Kennedy 4940 Eastern Ave Baltimore MD 21224

31. Date filed (Month, Day, Year)

JAN 02 1998

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 97 39950

Physician  
/Medical  
Examiner

Brandon J. Kinzer

2. Date of Death  
Month Day Year  
DECEMBER 27, 1997  
3. Time of Death  
0406 AFuneral  
Director

4a. Facility Name (If not institution, give street and number)

PRINCE GEORGES HOSPITAL CENTER

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

PRINCE GEORGES

5. Social Security Number

N/A

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

Dec. 5, 1927

9. Birthplace (State or Foreign Country)

Cheverly Md.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Seat Pleasant

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

306 69th Place

10f. Zip Code

20743

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

N/A

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

George C. Kinzer, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Annie L. Walls

19a. Informant's Name/Relationship (Type, Print)

George C. Kinzer, Jr. Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

306 69th Place Seat Pleasant Maryland 20743

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Barnabas Cemetery

Date

Dec. 30, 1997

20c. Location - City or Town, State

Upper Marlboro Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Robert E. Evans Funeral Home, Inc.

16000 Annapolis Rd. Bowie Maryland 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SUDDEN INFANT DEATH SYNDROME

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending Investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

OCME

29d. Date signed (Month, Day, Year)

DECEMBER 28, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

J. Allen Locke, MD 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JAN 02 1998

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Item : 8 Per FH Film G-754 1-2-98RC

97 39951

Lewis, James

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>James Lewis</b>  |  | 2. Date of Death<br>Month <b>December</b> Day <b>26</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>6:25 PM</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Genesis ElderCare Caton Manor Baltimore City</b>   |  | 4b. City, Town, or Location of Death<br><b>NA</b>   |  | 4c. County of Death<br><b>NA</b>  |  |
| 5. Social Security Number<br><b>579-14-8387</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.  |  |
| 8. Date of Birth (Month, Day, Year)<br><b>7-2-3-9-14</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Va</b>   |  |   |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>NA</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>   |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>623 N. Rosedale Street</b>   |  | 10f. Zip Code<br><b>21216</b>   |  |
| 10g. Citizen of What Country?<br><b>USA</b>   |  | 11. Marital Status<br><input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                              |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>10-31-42 4-7-46</b>  |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12): <b>12th grade</b><br>College (1-4 or 5+): <b>NA</b>   |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Maintenance</b>   |  | 16b. Kind of Business/Industry<br><b>Security</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>James Lewis</b>   |  |
| 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Florence</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ida J. Lewis - wife</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>623 N. Rosedale Street Baltimore MD 21216</b>   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garrison Forest Vet</b>  |  | 20c. Location - City or Town, State<br><b>1-2-98 Owings Mills, MD 21215</b>   |  |
| 21. Signature of Funeral Service Licensee<br><b>Rosa C. James</b>   |  | 22. Name and Address of Facility<br><b>March H. West 4302 Wabash Avenue Baltimore MD</b>  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Carcinoma of the Male Breast</b>  |  |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Old Cerebrovascular Accident</b>  |  | 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how Injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>Whymie M7 Attending Doctor</b>  |  | 29c. License number<br><b>D 21684</b>   |  |
| 29d. Date signed (Month, Day, Year)<br><b>12-27-97</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>C-V-LYRIK-MD 5109 RITCHIE HWY, PASADENA, MD 21122</b>  |  | 31. Data filed (Month, Day, Year)<br><b>JAN 02 1998</b>   |  |
| 32. Registrar's Signature<br><b>John Davidson-Randall</b>   |  |   |  |   |  |



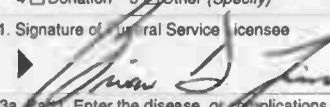
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 39952

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |   |   |  |
|---|--|--|---|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Helen F. LHOTSKY</b>  |  |   |  | 2. Date of Death<br>Month <b>December</b> Day <b>29</b> Year <b>1997</b>   |   | 3. Time of Death<br><b>10:25 P.M.</b>                                   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Franklin Square Hospital Center</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Rosedale</b>  |   | 4c. County of Death<br><b>Baltimore</b>                                 |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>217-24-7409</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>68</b>  |   | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 3, 1929</b>              |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>N/A</b>  |   | 10c. City, Town or Location<br><b>Baltimore</b>                         |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>5847 Daybreak Terrace</b>  |  | 10f. Zip Code<br><b>21206</b>  |   | 10g. Citizen of What Country?<br><b>U. S. A.</b>                        |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>11th Grade</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                         |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |   |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>John Lhotsky</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Catherine Lang</b>   |   |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>James J. Lhotsky (Husband)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5847 Daybreak Terrace, Baltimore, Maryland 21206</b>   |   |   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gardens of Faith</b>   |  | Date<br><b>1/2/98</b>  |   | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>       |  |
|   | 21. Signature of Funeral Service licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Schmunek Funeral Home Inc.</b><br><b>3331 Brehms Lane, Baltimore, Maryland 21213</b>  |   |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>e. <b>Coronary artery disease</b><br>Due to (or as a consequence of):<br><br>b. <b>Renal failure</b><br>Due to (or as a consequence of):<br><br>c. <b>Insulin dependent mellitus</b><br>Due to (or as a consequence of):<br><br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  |  |   |   | Approximate Interval Between Onset and Death<br><b>10 years</b>  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  | 28a. Date of Injury (Month, Day Year)<br><b>28b. Time of Injury</b><br><b>M</b><br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |
| 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |  |  |   |   |  |
| 29b. Signature and title of certifier<br>  |  |  |   | 29c. License number<br><b>D28214</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>December 31, 1997</b>   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Julie Casani 9000 Franklin Square Dr. Baltimore, Maryland 21237</b>  |  |  |   |  |  |   |   |  |
| 31. Data filed (Month, Day, Year)<br><b>JAN 02 1998</b>   |  |  |   | 32. Registrar's Signature<br>   |  |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39953

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JUDITH WARRENFELTZ LOANE

2. Date of Death  
Month Day Year  
December 30 1997

3. Time of Death

1pm

4a. Facility Name (If not Institution, give street and number)

GILCHRIST CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE COUNTY

Funeral  
Director

5. Social Security Number

214-32-4234

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

64

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Oct 24, 1933

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore County

10c. City, Town or Location

Cockeysville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

911 Saxon Hill Drive

10f. Zip Code

21030

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Registered Nurse

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

Herbert Reginald Warrenfeltz

18. Mother's Name (First, Middle, Maiden Surname)

Olivia Hooker

19a. Informant's Name/Relationship (Type, Print)

Beverly L. Davis (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2013 Brandy Drive, Forest Hill, Maryland 21050

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Druid Ridge Cemetery

Date

1/3/98

20c. Location - City or Town, State

Pikesville, Maryland

21. Signature of Funeral Service Licensee

John O. Mitchell, IV

22. Name and Address of Facility

Mitchell-Wiedefeld Home

6500 York Road, Baltimore, Maryland 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Metastatic cancer of the tongue

Approximate Interval Between Onset and Death

9 months

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

John O. Mitchell, IV

29c. License number

D25205

29d. Date signed (Month, Day, Year)

December 30, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. A. R. Taylor, Jr. 6701 N. Charles St. Baltimore, Md. 21204

31. Date filed (Month, Day, Year)

JAN 02 1998

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



97 39954

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Robert Lewis, Jr.</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>12</b> DAY <b>30</b> YEAR <b>97</b>   |  | 3. TIME OF DEATH<br><b>0622</b> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-80-5408</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>39</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>12-2-58</b>  |  |
| 9a. FACILITY NAME (If not Institution, give street and number)<br><b>Maryland State Penitentiary</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>  |  | 9c. COUNTY OF DEATH<br><b>n/a</b>   |  |
| RESIDENCE OF DECEDENT   |  |  |  |  |  |   |  |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>n/a</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO           |  |
| 10e. STREET AND NUMBER<br><b>4527 Pimlico Rd.</b>   |  |  |  | 10f. ZIP CODE<br><b>21215</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>if yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10th</b> College (1-4 or 5+) <b>Laborer</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Laborer</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Roofing</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Robert L. Lewis, Sr.</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Marjorie R. Ross</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Marjorie Lewis/mother</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4527 Pimlico Rd. Balto., MD 21215</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>King Memorial Park 1/3/98 Randallstown, MD</b>   |  | 20c. LOCATION — City or Town, State   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>James A. Morton</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>James A. Morton &amp; Sons Funeral Home<br/>1701 Laurens St. Balto., MD 21217</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>AIDS</b><br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. |  |  |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Prison</b> |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                              |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Patricia G. Wright M.D.</b>  |  |   |  |
| 29c. LICENSE NUMBER<br><b>D41235</b>  |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>12-30-97</b>   |  |   |  |
| NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>954 Forrest St. Baltimore, Md. 21202</b>  |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JAN 02 1998</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

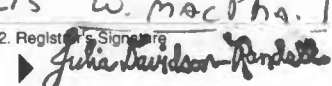
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

Reg. No.

97 39955

|  |   |  |   |                                      |  |  |  |
|--|---|--|---|--------------------------------------|--|--|--|
| <b>Physician<br/>/Medical<br/>Examiner</b> | 1. Decedent's Name (First, Middle, Last)<br><b>CODINE LEWIS</b>   |  |   |                                      | 2. Date of Death<br>Month <b>12</b> Day <b>29</b> Year <b>97</b>   |  | 3. Time of Death<br><b>6:55PM</b>  |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>Mariner Health of Forest Hill</b>  |  |   |                                      | 4b. City, Town, or Location of Death<br><b>Forest Hill</b>   |  | 4c. County of Death<br><b>Harford</b>  |
| <b>Funeral<br/>Director</b>                | 5. Social Security Number<br><b>236-16-2045</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.  | If Under 1 Year<br>Months            | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>May 5, 1919</b>                                      | 9. Birthplace (State or Foreign Country)<br><b>Waiteville, W. VA.</b>  |
|  | Usual Residence of Decedent   |  |   |                                      |  |  |  |
| <b>To Be Completed by Funeral Director</b> | 10e. State<br><b>Maryland</b>   | 10b. County<br><b>Baltimore</b>  | 10c. City, Town or Location<br><b>Fork</b>  |                                      |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | 10e. Street and Number<br><b>12712 Fork Road</b>  |  |   | 10f. Zip Code<br><b>21051</b>        |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th.</b>   |  | College (1-4 or 5+) <b>2 yrs.</b>   |                                      | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Accountant</b>  |  | 16b. Kind of Business/Industry<br><b>Maryland General Hospital</b>   |
|  | 17. Father's Name (First, Middle, Last)<br><b>Cody C. Mottesheard</b>   |  |   |                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Melvie McCormick</b>   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Carole Seim (Sister)</b>   |  |   |                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12712 Fork Road Fork, Md. 21051</b>  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Zion Church Cemetery</b>   |                                      | Date<br><b>1/3/98</b>  | 20c. Location - City or Town, State<br><b>Waiteville, W. Va.</b>                               |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  |   |                                      | 22. Name and Address of Facility<br><b>E. F. Lassahn Funeral Home<br/>11750 Belair Road Kingsville, Md. 21087</b>  |  |  |
|  | 23e. Part I. Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |                                      |  |  |  |
|  | <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <u>progressive dementia</u><br/>Due to (or as a consequence of):</p> <p>b. _____<br/>Due to (or as a consequence of):</p> <p>c. _____<br/>Due to (or as a consequence of):</p> <p>d. _____<br/>Due to (or as a consequence of):</p> </div> <div style="width: 35%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p><b>&gt; 5 years</b></p> </div> </div> |  |   |                                      |  |  |  |
| <b>Physician<br/>/Medical<br/>Examiner</b> | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>breast cancer</u><br><u>atrial fibrillation</u>  |  |   |                                      |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|  |   |  |   |                                      |  |  | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|  |   |  |   |                                      |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                      |  |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   | 28b. Time of Injury<br><b>M</b>      | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 28d. Describe how injury occurred  |  |
|  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                                      |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                   |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |                                      |  |  |  |
|  | 29b. Signature and title of certifier<br>  |  |   | 29c. License number<br><b>032259</b> |  | 29d. Date signed (Month, Day, Year)<br><b>December 30, 1997</b>                                |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DAVID S. DUNN 415 W. MacPhail</b>  |  |   |                                      |  |  |  |
|  | 31. Date filed (Month, Day, Year)<br><b>JAN 02 1998</b>   |  | 32. Registrar's Signature<br>  |                                      |  |  |  |

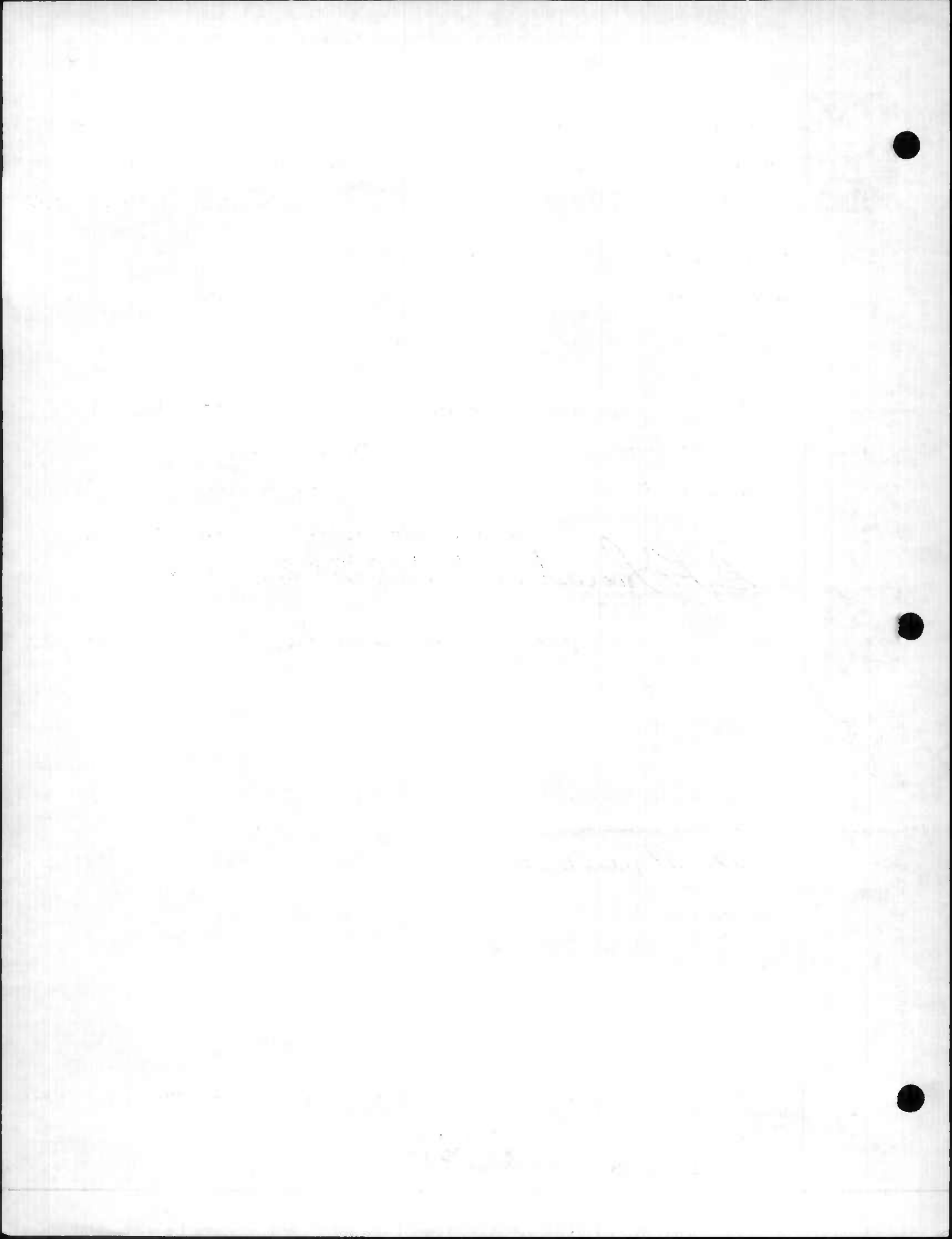
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the funeral-transit permit.

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39956

|  |  |  |   |  |  |  |   |  |   |  |  |
|--|--|--|---|--|--|--|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Evelyn G. Livingston</b>                      |  |   |  |  |  | 2. Date of Death<br>Month Day Year<br><b>Dec 30 1997</b>                                    |  | 3. Time of Death<br><b>6:05 PM</b>                                      |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>3208 Gibbons Avenue</b> |  |   |  |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore Md</b>                                 |  | 4c. County of Death<br><b>N/A</b>                                       |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-32-7330</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs. |  | 8. Date of Birth (Month, Day, Year)<br><b>Mar 7 1916</b>                                    |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>             |  |  |
|  | Usual Residence of Decedent  |  |   |  |  |  | 10a. State<br><b>Md</b>   |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore, Md.</b> |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |   |  |  | 10e. Street and Number<br><b>3208 Gibbons Avenue</b>   |   | 10f. Zip Code<br><b>21214</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10th</b><br>College (1-4or 5+) <b>N/A</b>  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>self</b>  |  |  | 16b. Kind of Business/Industry<br><b>Grocery Store</b>   |   |  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>William Charvat</b>  |  |  |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mamie Navratil</b>   |   |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Wilma M. Whalen/daughter</b>  |  |  |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3208 Gibbons Ave., Baltimore, Md. 21214</b>  |   |  |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parkwood Cemetery</b>  |  |  | 20c. Date<br><b>1/3/98</b>   |   | 20d. Location - City or Town, State<br><b>Baltimore, Md.</b>   |   |  |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  |  |   |  |  | 22. Name and Address of Facility<br><b>Hartley Miller Funeral Home<br/>7527 Harford Rd. Baltimore, Md. 21214</b>   |   |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Peritoneal carcinomatosis (ovarian origin)</b><br>Due to (or as a consequence of):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. 20 months</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b> |  |  |   |  |  |  |   |  |   | Approximate Interval Between Onset and Death |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>chronic obstructive lung disease due to eosinophilic pneumonia</b><br><b>chronic prednison use</b>  |  |  |   |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  |  | 28a. Date of Injury (Month, Day, Year)<br><b>N/A</b>  |  | 28b. Time of Injury<br><b>M</b>                  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred<br><b>N/A</b>                         |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>N/A</b>   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |   |  |  |  |   |  |   |  |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>  |  |  |   |  |  | 29c. License number<br><b>D44290</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>2 January 1998</b>   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>TIMOTHY L. KRONE, MD 10755 Falls Road, Suite 200, Lutherville, MD 21093</b>   |  |  |   |  |  |  |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 02 1998</b>  |  |  |   |  |  | 32. Registrar's Signature<br><i>[Signature]</i>  |   |  |   |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Rufus

2. Date of Death

Month

Day

Year

3. Time of Death

630 am.

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL Baltimore

4b. City, Town, or Location of Death

4c. County of Death

NA

Funeral  
Director

5. Social Security Number

215-242427

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Month

Day

Year

Dec 5, 1928

9. Birthplace (State or Foreign Country)

Md

Usual Residence of Decedent

10a. State

Md

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

301 Mc Mechen Street

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ENGINEER

16b. Kind of Business/Industry

Dept. of Education

17. Father's Name (First, Middle, Last)

Henry McIntosh

18. Mother's Name (First, Middle, Maiden Surname)

Edna Gaskins

19a. Informant's Name/Relationship (Type, Print)

Sheila Harris - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11410 Braille St. Detroit, Michigan 48228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King Memorial Park

Date

1-2-98

20c. Location - City or Town, State

Randallstown, Md

21. Signature of Funeral Service Licensee

Sheila March

22. Name and Address of Facility

Wm C. March Funeral Home West Inc  
4300 Wabash Ave Balto Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. lung cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 years.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pseudomonal pneumonia

Adult Respiratory Distress Syndrome

left atrial clot.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Bart Scott MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

December 27, 1997.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bart Scott MD, Johns Hopkins Hospital.

31. Date filed (Month, Day, Year)

JAN 02 1998

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

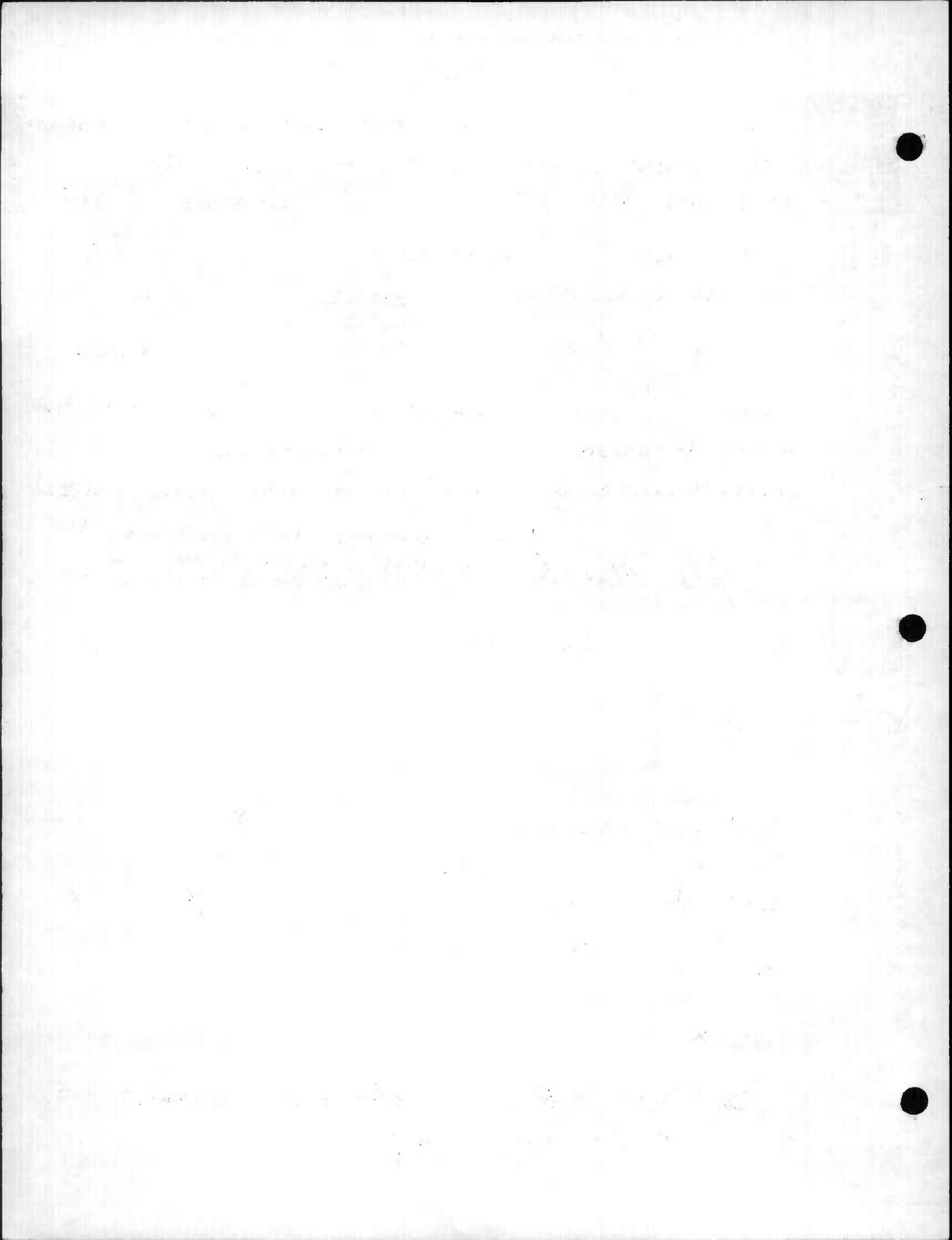
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68768

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 39959

Item: 10e Per FH Film G-754 1-2-98RC

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |  |   |  |
|---|--|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Clyde T. Morrison</b>   |  |   |  | 2. Date of Death<br>Month <b>December</b> Day <b>28</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>0625AM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Sinai Hospital</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>Baltimore</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>247-44-2211</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>67</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 28 1930</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>S.C.</b>  |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>NA</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>   |  |
| To Be Completed by Funeral Director           | Usual Residence of Decedent  |  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |
|   | 10e. Street and Number<br><b>3919 BAREVA ROAD</b>  |  |   |  | 10f. Zip Code<br><b>21215</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>NA</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>STEEL WORKER</b>  |  | 16b. Kind of Business/Industry<br><b>Bethlehem Steel</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>JUNIE MORRISON</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Alfair Brown</b>   |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Elizabeth Morrison - wife</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3919 Bareva Rd. Balto Md. 21215</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Loudon Pk. Cem.</b>  |  | 20c. Date<br><b>12-98</b>  |  | 20d. Location - City or Town, State<br><b>Balto. Md</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Phyllis B. Harris</b>  |  | 22. Name and Address of Facility<br><b>Wm C. March Funeral Home West Inc.<br/>4300 Wabash Ave. Balto. Md 21215</b>  |  |  |  |   |  |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hemorrhage. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Pneumonia</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>cerebrovascular accident</b><br><b>diabetes, renal insufficiency</b><br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |  |   |  |  |  | Approximate Interval Between Onset and Death<br><b>24 hrs</b>   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>seizure disorder</b><br><b>cerebrovascular accident</b><br><b>diabetes, renal insufficiency</b>   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |   |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|   | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br><b>Mark Wahl, MD</b>   |  | 29c. License number<br><b>AS 2402321 mw 9515</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>December 28, 1997</b>   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Mark Wahl, MD Sinai Hospital, Baltimore, Maryland</b>   |  |   |  |  |  |   |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>JAN 02 1998</b>  |  | 32. Registrar's Signature<br><b>J. Davidson-Randall</b>   |  |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39960

|  |  |   |  |   |   |  |  |  |  |
|--|--|---|--|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Robert Watson Medley                         |   |  |   | 2. Date of Death<br>Month Day Year<br>December 31, 1997 |  | 3. Time of Death<br>15:00                              |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>North Arundel Hospital |   |  |   | 4b. City, Town, or Location of Death<br>Glen Burnie     |  | 4c. County of Death<br>Anne Arundel                    |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>255-24-1734   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br>83 Yrs.               |  | 8. Date of Birth (Month, Day, Year)<br>August 23, 1914 |  |  |
|  | 9. Birthplace (State or Foreign Country)<br>Georgia                                      |   | 10a. State<br>MD   |   | 10b. County<br>Anne Arundel                             |  | 10c. City, Town or Location<br>Odenton                 |  |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br>300 Nevada Avenue   |  | 10f. Zip Code<br>21113  |   | 10g. Citizen of What Country?<br>USA   |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 6 College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Truck Driver                         |  | 16b. Kind of Business/Industry<br>Paint Company   |   |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Charles Monroe Medley   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Susan Jackson  |   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Dwight Daniel - Grandchild   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>440 Magothy Bridge Rd., Pasadena, MD 21122   |   |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Glen Haven Cemetery   |  | 20c. Location - City or Town, State<br>1/3/98 Glen Burnie, Maryland   |   |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>▶ <i>Robert J. Arnold</i>   |  | 22. Name and Address of Facility<br>Hardesty Funeral Home, P.A.<br>12 Ridgely Avenue, Annapolis, MD 21401   |  |   |   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>a. Massive Left Basal Ganglia Bleed<br>Due to (or as a consequence of):<br>b. Hypertension<br>Due to (or as a consequence of):<br>c. Cerebrovascular Accident<br>Due to (or as a consequence of):<br>d. Hypertension |  |   |  |   |   |  |  | Approximate Interval Between Onset and Death |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |   |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |   |  |   |   |  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |   |   |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |   |   |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |   |   |  |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |   |  |   |   |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |  |
| 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |   |   |  |  |  |  |
| 29b. Signature and title of certifier<br>▶ <i>Dr. Mirza Nusaire</i>  |  |   |  | 29c. License number<br>D40519   |   | 29d. Date signed (Month/Day/Year)<br>12/31/97  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dr. Mirza Nusaire North Arundel Hospital, Glen Burnie, MD  |  |   |  |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>JAN 02 1998   |  |   |  |   |   |  |  |  |  |
| 32. Registrar's Signature<br><i>John Davidson-Randall</i>  |  |   |  |   |   |  |  |  |  |



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State of Maryland / Department of Health and Mental Hygiene 97 39961

## Certificate of Death

Reg. No.

|  |  |  |  |                                |  |
|--|--|--|--|--------------------------------|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><i>Helen E. Napier</i>   |  | 2. Date of Death<br>Month <i>December</i> Day <i>23</i> Year <i>1997</i>   |                                | 3. Time of Death<br><i>4:30 A.M.</i>   |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>Genesis Elder Care</i>  |  | 4b. City, Town, or Location of Death<br><i>Randallstown</i>  |                                | 4c. County of Death<br><i>Baltimore</i>  |
| Funeral<br>Director  | 5. Social Security Number<br><i>227-36-1527</i>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><i>63</i> Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|  | 8. Date of Birth (Month, Day, Year)<br><i>9-12-1934</i>  |  | 9. Birthplace (State or Foreign Country)<br><i>Va</i>  |                                |  |
| To Be Completed by Funeral Director                                  | Usual Residence of Decedent  |  |  |                                |  |
|  | 10a. State<br><i>Md</i>  | 10b. County<br><i>Balto</i>  | 10c. City, Town or Location<br><i>Randallstown</i>   |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|  | 10e. Street and Number<br><i>3604 Annie Hathaway Drive</i>   |  | 10f. Zip Code<br><i>21133</i>  |                                | 10g. Citizen of What Country?<br><i>U.S.A</i>  |
|  | 11. Marital Status<br><input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>Black</i>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12th grade</i> College (14 or 5+) <i>2 yrs</i>   |                                |  |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Day Care Teacher</i>   |  | 16b. Kind of Business/Industry<br><i>Day Care</i>  |                                |  |
|  | 17. Father's Name (First, Middle, Last)<br><i>William Roane</i>  |  | 18. Mother's Name (First, Middle, Maiden Sumame)<br><i>Irene</i>   |                                |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><i>Keslie Meredith Napier Daughter</i>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>3604 Annie Hathaway Drive Randallstown Md 21133</i>  |                                |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Garrison Forest</i>   |                                | 20c. Location - City or Town, State<br><i>12-30-97 Owings Mills, Md</i>  |
|  | 21. Signature of Funeral Service Licensee<br><i>John B. Johnson</i>  |  | 22. Name and Address of Facility<br><i>Mark F.H. West 4300 Wabash Avenue Balto, Md 21215</i>   |                                |  |
| Physician<br>/Medical<br>Examiner                                    | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Metastatic Carcinoma of the Breast</i><br>Due to (or as a consequence of):<br>b. <i>Chronic Lung Disease</i><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |                                |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Inability to Swallow</i>  |  |  |                                |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |                                |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |                                |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)   | 28b. Time of Injury<br>M       | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|  | 28d. Describe how Injury occurred  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |                                |  |
|  | 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |                                |  |
| State Registrar  | 29b. Signature and title of certifier<br><i>Robert K. Koppman MD</i>   |  | 29c. License number<br><i>D14753</i>   |                                | 29d. Date signed (Month, Day, Year)<br><i>12/24/97</i>   |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Plaza Mall 8020 Liberty Road Randallstown, Md 21133</i>   |  |  |                                |  |
| 31. Date filed (Month, Day, Year)<br><i>JAN 02 1998</i>              |  | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>                 |  |                                |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



WRC  
97-7414-510  
FELIPA CLEMENTE  
ROBINSON

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

37 39962

Baltimore, Maryland 21215-0020  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68768  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>FELIPA C. ROBINSON</b>   |  | 2. Date of Death<br>Month Day Year<br><b>DEC. 23, 1997</b>  |  | 3. Time of Death<br><b>9:13 PM.</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>SHOCK TRUMA</b>  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death<br><b>NA</b>   |  |
| 5. Social Security Number<br><b>212-24-7180</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>16</b> Yrs.   |  |
| 8. Date of Birth (Month, Day, Year)<br><b>May 6, 1981</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |  |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>NA</b>  |  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>761 LINNARD STREET</b>   |  | 10f. Zip Code<br><b>21229</b>  |  |
| 10g. Citizen of What Country?<br><b>USA</b>   |  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                            |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9th</b> College (1-4or 5+) <b>NA</b>   |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>STUDENT</b>   |  | 16b. Kind of Business/Industry<br><b>SCHOOL</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>JEFFREY BROWN</b>  |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>FELICIA ROBINSON</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>FELICIA ROBINSON-MOTHER</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>761 LINNARD STREET BALTO., MD 21229</b>  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Zion Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>Balto., Md</b>   |  |
| 21. Signature of Funeral Service Licensee<br><i>Shannon Stokes</i>  |  | 22. Name and Address of Facility<br><b>Wm. C. March Funeral Home West, Inc.<br/>4300 Wabash Ave. Balto., Md 21215</b>   |  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>GUL SHOT WOUNDS (2) TO TORSO</b>   |  |
| 23b. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>GUL SHOT WOUNDS (2) TO TORSO</b>  |  | 23c. Part 3. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. |  | Approximate Interval Between Onset and Death   |  |
| 24. Immediate Cause (Final disease or condition resulting in death)<br><b>GUL SHOT WOUNDS (2) TO TORSO</b>  |  | 25. Due to (or as a consequence of):  |  |  |  |
| 26. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  |  | 27. Due to (or as a consequence of):  |  |  |  |
| 28. Due to (or as a consequence of):  |  | 29. Due to (or as a consequence of):  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  | 30. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown           |  | 31. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 32. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 33. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 34. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| 35. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 36. Date of Injury (Month, Day Year)<br><b>12 23 97</b>   |  | 37. Time of Injury<br><b>2100P M</b>   |  |
| 38. Injury of Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 39. Describe how injury occurred<br><b>SUSPECT WAS SHOT.</b>  |  | 40. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>600 BLK DENNIS ST BALTIMORE MD</b>   |  |
| 41. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 42. Signature and title of certifier<br><i>Maguire Melchior</i>   |  | 43. License number<br><b>O.C.M.E.</b>  |  |
| 44. Date signed (Month, Day, Year)<br><b>DECEMBER 24, 1997</b>  |  | 45. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>HARRY D. A. KOREN 111 Penn Street, Baltimore, Maryland 21201</b>   |  | 46. Date filed (Month, Day, Year)<br><b>JAN 02 1998</b>  |  |
| 47. Registrar's Signature<br><i>Julia Davidson-Randall</i>  |  |   |  |  |  |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39963

|   |  |                               |   |  |  |  |  |   |  |  |
|---|--|-------------------------------|---|--|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner                       | 1. Decedent's Name (First, Middle, Last)<br><b>Mary Buck Rowe</b>  |                               |   |  |  |  | 2. Date of Death<br>Month Day Year<br><b>December 27, 1997</b>   |   | 3. Time of Death<br><b>11:30 AM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Baptist Home of Maryland</b>  |                               |   |  |  |  | 4b. City, Town, or Location of Death<br><b>Owings Mills</b>  |   | 4c. County of Death<br><b>Baltimore</b>  |  |
| Funeral<br>Director                                     | 5. Social Security Number<br><b>220-30-3141</b>  |                               | 6. Sex<br><b>1 M 2 F</b>  |  | 7. Age (In yrs. last birthday)<br><b>102</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>June 9, 1895</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>Va.</b>   |  |
|   | Usual Residence of Decedent  |                               |   |  |  |  |  |   |  |  |
| To Be Completed by Funeral Director                     | 10a. State<br><b>Md.</b>   |                               | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Owings Mills</b>   |  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|   | 10e. Street and Number<br><b>10729 Park Heights Ave.</b>   |                               |   |  | 10f. Zip Code<br><b>21117</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |                               | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+)   |                               | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary</b>  |  |  |  | 18b. Kind of Business/Industry<br><b>Clerical</b>  |   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>William Richardson Buck</b>  |                               |   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Annie Wallace</b>  |   |  |  |
| To Be Completed by Physician/Medical Examiner           | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. George D. Rowe, Jr./ Son</b>  |                               |   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Box 145 Wycombe, Pa. 18980</b>   |   |  |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |                               | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hilltop Service Corp.</b>  |  | Date<br><b>12/31/97</b>  |  | 20c. Location - City or Town, State<br><b>Towson, Maryland</b>   |   |  |  |
|   | 21. Signature of Funeral Service Licensee<br>  |                               | 22. Name and Address of Facility<br><b>Ruck Towson Funeral Home, Inc.<br/>1050 York Road Towson, Maryland 21204</b>   |  |  |  |  |   |  |  |
|   | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |                               |   |  |  |  |  |   |  |  |
|   | <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>coronary artery disease</b><br/>Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> <p>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> |                               |   |  |  |  |  |   |  |  |
| To Be Completed by Physician/Medical Examiner           | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |                               |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |  |
|   |  |                               |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                               | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |   |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |                               | 28a. Date of Injury (Month, Day, Year)<br><b>N/A</b>  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred  |  |
|   |  |                               | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |
| State Registrar   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                            |                               |   |  |  |  |  |   |  |  |
|   | 29b. Signature and title of certifier<br>  |                               |   |  | 29c. License number<br><b>D41104</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>12.30.97</b>   |   |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Ted Houch MD 7825 York Rd Towson MD 21204</b>   |                               |   |  |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 02 1998</b> |  | 32. Registrar's Signature<br> |   |  |  |  |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39964

|  |   |   |   |  |   |   |   |
|--|---|---|---|--|---|---|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><i>Fannie B. Smock</i>  |   |   | 2. Date of Death<br>Month <i>December</i> Day <i>20</i> Year <i>1997</i>   |   | 3. Time of Death<br><i>11:20 Am</i>   |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>Genesis N.H.</i>   |   |   | 4b. City, Town, or Location of Death<br><i>Towson</i>  |   | 4c. County of Death<br><i>Balto</i>   |   |
| Funeral<br>Director  | 5. Social Security Number<br><i>407-12-7901</i>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><i>91</i> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth<br>(Month, Day, Year)<br><i>9-6-06</i>   | 9. Birthplace (State or Foreign Country)<br><i>Kentucky</i>             |
|  | Usual Residence of Decedent   |   |   |  |   |   |   |
| To Be Completed by Funeral Director  | 10a. State<br><i>Md</i>   | 10b. County<br><i>NA</i>  | 10c. City, Town or Location<br><i>Baltimore</i>   |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |
|  | 10e. Street and Number<br><i>3617 Darley Lane</i>   |   |   | 10f. Zip Code<br><i>21207</i>  |   | 10g. Citizen of What Country?<br><i>U.S.A</i>   |   |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>Black</i> |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12th grade</i> College (1-4 or 5+) <i>4 yrs</i>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Supervisor</i>                    |  | 16b. Kind of Business/Industry<br><i>Department of Social Service</i>   |   |   |
|  | 17. Father's Name (First, Middle, Last)<br><i>Benjamin Clay</i>   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Phoebe</i>   |   |   |   |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><i>Marlene F. Opaca - Daughter</i>  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>3617 Darley Lane Baltimore 21207</i> |   |   |   |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Frankfort Cemetery</i>   |  | 20c. Location - City or Town, State<br><i>Frankfort, Kentucky</i>   |   |   |
|  | 21. Signature of Funeral Service Licensee<br><i>Bladys Wane</i>   |   |   | 22. Name and Address of Facility<br><i>March Fit West 4300 Wabash Avenue Balto. Md 21215</i>   |   |   |   |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <i>PNEUMONIA</i><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |   |   |  |   |   |   |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |   |  |   |   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |  |   | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                   |   |
|  |   |   |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |   |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |
|  |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28d. Describe how injury occurred  |   |   |   |
|  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |   |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |  |   |   |   |
| 29b. Signature and title of certifier<br><i>Raymond A. Azem</i>  |   |   |   | 29c. License number<br><i>D34184</i>   |   | 29d. Date signed (Month, Day, Year)<br><i>12/22/97</i>  |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><i>RAYMOND A. AZEM PA, 7801 YORK RD #300, TOWSON, MD 21204</i>   |   |   |   |  |   |   |   |
| 31. Date filed (Month, Day, Year)<br><i>JAN 02 1998</i>  |   | 32. Registrar's Signature<br><i>Jake Davidson-Randall</i>   |   |  |   |   |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68769



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39965

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Howard Stokes

2. Date of Death

Month  
12

Day  
31

Year  
97

3. Time of Death

23:52

4a. Facility Name (If not institution, give street and number)

UNIVERSITY OF MARYLAND MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

n/a

Funeral  
Director

5. Social Security Number

219-10-6574

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 19, 1924

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1922 Riggs Ave.

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Steel Worker

16b. Kind of Business/Industry

Bethlehem Steel

17. Father's Name (First, Middle, Last)

Phillip Stokes

18. Mother's Name (First, Middle, Maiden Surname)

Nannie Brown

19a. Informant's Name/Relationship (Type, Print)

Rosia Stokes/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1922 Riggs Ave. Balto., MD 21217

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest VA 1/6/98 Owings Mills, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

James A. Morton

22. Name and Address of Facility

James A. Morton & Sons Funeral Home  
1701 Laurens St. Balto., MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Coronary artery disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. diffuse atherosclerosis

Due to (or as a consequence of):

years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End stage renal disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

28. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Bonnet MD

29c. License number

D44498

29d. Date signed (Month, Day, Year)

11/1/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRET BORCHERT, MD 22 S. GREEVE ST BALTIMORE, MD 21201

31. Date filed (Month, Day, Year)

JAN 02 1998

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68769

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39966

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RAYMOND EUGENE SIMS

2. Date of Death

DEC. 28, 1997

3. Time of Death

1308 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS HOSPITAL - N.C.C.U

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

229-86-4750

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

59 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

JUNE 18, 1938

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1308 N. KENWOOD AVE

10f. Zip Code

21213

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12 YEARS

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MACHINIST

16b. Kind of Business/Industry

PRIVATE BUSINESS

17. Father's Name (First, Middle, Last)

Joseph Sims

18. Mother's Name (First, Middle, Maiden Surname)

Phyllis Hatchett

19a. Informant's Name/Relationship (Type, Print)

STEPHANIE SIMS /WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1308 N. KENWOOD AVE BALTIMORE, MD 21213

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

VASHILL MEMORIAL CEMETERY

Date

1-2-98

20c. Location - City or Town, State

DUNDALK MD

21. Signature of Funeral Service Licensee

Geray Harris

22. Name and Address of Facility

CHATMAN-HOMER F.H.  
5340 REISTER ROAD  
BALTIMORE, MD 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Gunshot Wound of Head

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No25. Was case referred to medical examiner?  
XX Yes 2 ☐ No

Hospital:

XX Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☒ Homicide

28a. Date of Injury (Month, Day, Year)

12/27/97

28b. Time of Injury

1204 M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

subject shot

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

street

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2400 E. Oliver Street  
Baltimore, Md

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

XX Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dennis J. Chute, MD

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

DEC. 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis J. Chute, MD

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JAN 02 1998

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,



97 39967

DMMH 16 Rev 6/95

**Physician /Medical Examiner**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**To the Funeral Director:** After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

**Medical Certification: To Be Completed by Physician/Medical Examiner**

!SPEAR, HAZE!

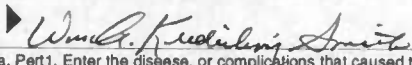
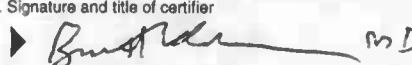



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 39968

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |  |  |  |   |                     |  |                                  |                                |                                  |   |    |  |
|---|--|--|---|--|--|--|--|--|---|---------------------|--|----------------------------------|--------------------------------|----------------------------------|---|----|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>MILDRED SANDERS</b>   |  |   |  | 2. Date of Death<br>Month <b>December</b> Day <b>30</b> , Year <b>1997</b>   |  | 3. Time of Death<br><b>12:15 A.M.</b>  |  |   |                     |  |                                  |                                |                                  |   |    |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Hebrew Home Of Greater Washington</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Rockville</b>   |  | 4c. County of Death<br><b>Montgomery</b>   |  |   |                     |  |                                  |                                |                                  |   |    |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-18-3904</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 16, 1913</b>  |  |   |                     |  |                                  |                                |                                  |   |    |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Russia</b>  |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>   |  | 10c. City, Town or Location<br><b>Rockville</b>  |  |   |                     |  |                                  |                                |                                  |   |    |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent  |  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |   |                     |  |                                  |                                |                                  |   |    |  |
|   | 10e. Street and Number<br><b>6121 Montrose Road</b>  |  |   |  | 10f. Zip Code<br><b>20852</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |   |                     |  |                                  |                                |                                  |   |    |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |                     |  |                                  |                                |                                  |   |    |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 Years</b>   |  | College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |   |                     |  |                                  |                                |                                  |   |    |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>(Unascertainable)</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sonia (Unascertainable)</b>  |  |  |  |   |                     |  |                                  |                                |                                  |   |    |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Diana Binder, Daughter</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>#1 Greenlane Court, Potomac, Maryland 20854</b>  |  |  |  |   |                     |  |                                  |                                |                                  |   |    |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>King David Memorial Garden</b>   |  | 20c. Location - City or Town, State<br><b>Falls Church, Virginia</b>   |  |  |  |   |                     |  |                                  |                                |                                  |   |    |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>STEIN HEBREW MEMORIAL FUNERAL HOME, INC.<br/>232 CARROLL STREET, NW, WASHINGTON, DC 20012</b>   |  |  |  |   |                     |  |                                  |                                |                                  |   |    |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |  |  |  |   |                     |  |                                  |                                |                                  |   |    |  |
|   | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>Pneumonia</b></td> <td rowspan="4">Approximate Interval Between Onset and Death<br/><b>1 day</b><br/><b>Years</b></td> </tr> <tr> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>b. <b>Alzheimer's dementia</b></td> </tr> <tr> <td>Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c.</td> <td rowspan="2"></td> </tr> <tr> <td>d.</td> </tr> </table> |  |   |  |  |  |  |  | Immediate Cause (Final disease or condition resulting in death) | a. <b>Pneumonia</b> | Approximate Interval Between Onset and Death<br><b>1 day</b><br><b>Years</b> | Due to (or as a consequence of): | b. <b>Alzheimer's dementia</b> | Due to (or as a consequence of): | Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. |  |
| Immediate Cause (Final disease or condition resulting in death)   | a. <b>Pneumonia</b>  | Approximate Interval Between Onset and Death<br><b>1 day</b><br><b>Years</b> |   |  |  |  |  |  |   |                     |  |                                  |                                |                                  |   |    |  |
|   | Due to (or as a consequence of):   |  |   |  |  |  |  |  |   |                     |  |                                  |                                |                                  |   |    |  |
|   | b. <b>Alzheimer's dementia</b>   |  |   |  |  |  |  |  |   |                     |  |                                  |                                |                                  |   |    |  |
|   | Due to (or as a consequence of):   |  |   |  |  |  |  |  |   |                     |  |                                  |                                |                                  |   |    |  |
| Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c.   |  |   |  |  |  |  |  |   |                     |  |                                  |                                |                                  |   |    |  |
|   | d.   |  |   |  |  |  |  |  |   |                     |  |                                  |                                |                                  |   |    |  |
| To Be Completed by Physician/Medical Examiner   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |                     |  |                                  |                                |                                  |   |    |  |
|   |  |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |                     |  |                                  |                                |                                  |   |    |  |
|   |  |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |                     |  |                                  |                                |                                  |   |    |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |   |                     |  |                                  |                                |                                  |   |    |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |                     |  |                                  |                                |                                  |   |    |  |
|   |  |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |                     |  |                                  |                                |                                  |   |    |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |  |  |   |                     |  |                                  |                                |                                  |   |    |  |
|   | 29b. Signature and title of certifier<br> <b>MD</b>   |  |   |  | 29c. License number<br><b>D 23958</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>12/30/97</b>   |  |   |                     |  |                                  |                                |                                  |   |    |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Burt I. Feldman, MD, 6105 Montrose Rd., Rockville, MD 20852</b>   |  |   |  |  |  |  |  |   |                     |  |                                  |                                |                                  |   |    |  |
|   | 31. Date filed (Month, Day, Year)<br><b>JAN 02 1998</b>  |  | 32. Registrar's Signature<br>  |  |  |  |  |  |   |                     |  |                                  |                                |                                  |   |    |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Item #5 perFH G755 1/9/98 EW

97 39969

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Harry Donald Summers

2. Date of Death

Month  
Dec.Day  
19Year  
1997

3. Time of Death

11:35 A.M.

4a. Facility Name (If not institution, give street and number)

12145 Long Ridge Lane

4b. City, Town, or Location of Death

Bowie

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

309-18-1892

6. Sex

XXX M 2 ☐ F

7. Age (In yrs. last birthday)

75

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

May 31, 1922

9. Birthplace (State or Foreign Country)

Indiana

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

12145 Long Ridge Lane

10f. Zip Code

20715

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

1 College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Management

16b. Kind of Business/Industry

Railroad

17. Father's Name (First, Middle, Last)

Cecil John Summers

18. Mother's Name (First, Middle, Maiden Surname)

Bernice Roark

19a. Informant's Name/Relationship (Type, Print)

Virginia R. Summers Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12145 Long Ridge Lane Bowie Maryland 20715

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resurrection Cemetery

Date

Dec. 23, 1997

20c. Location - City or Town, State

Clinton Maryland

21. Signature of Funeral Service Licensee

Michael L. Biehl

22. Name and Address of Facility

Robert E. Evans Funeral Home, Inc.

16000 Annapolis Rd. Bowie Maryland 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of death.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiopulmonary Arrest

Due to (or as a consequence of):

b. Large Cell Lymphoma Involving Lung

Due to (or as a consequence of):

c. Non-Hodgkins Lymphoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael R. Greener MD

29c. License number

D41765

29d. Date signed (Month, Day, Year)

12/22/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe Street Johns Hopkins Oncology Center, Baltimore, MD 21287

31. Date filed (Month, Day, Year)

JAN 02 1998

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

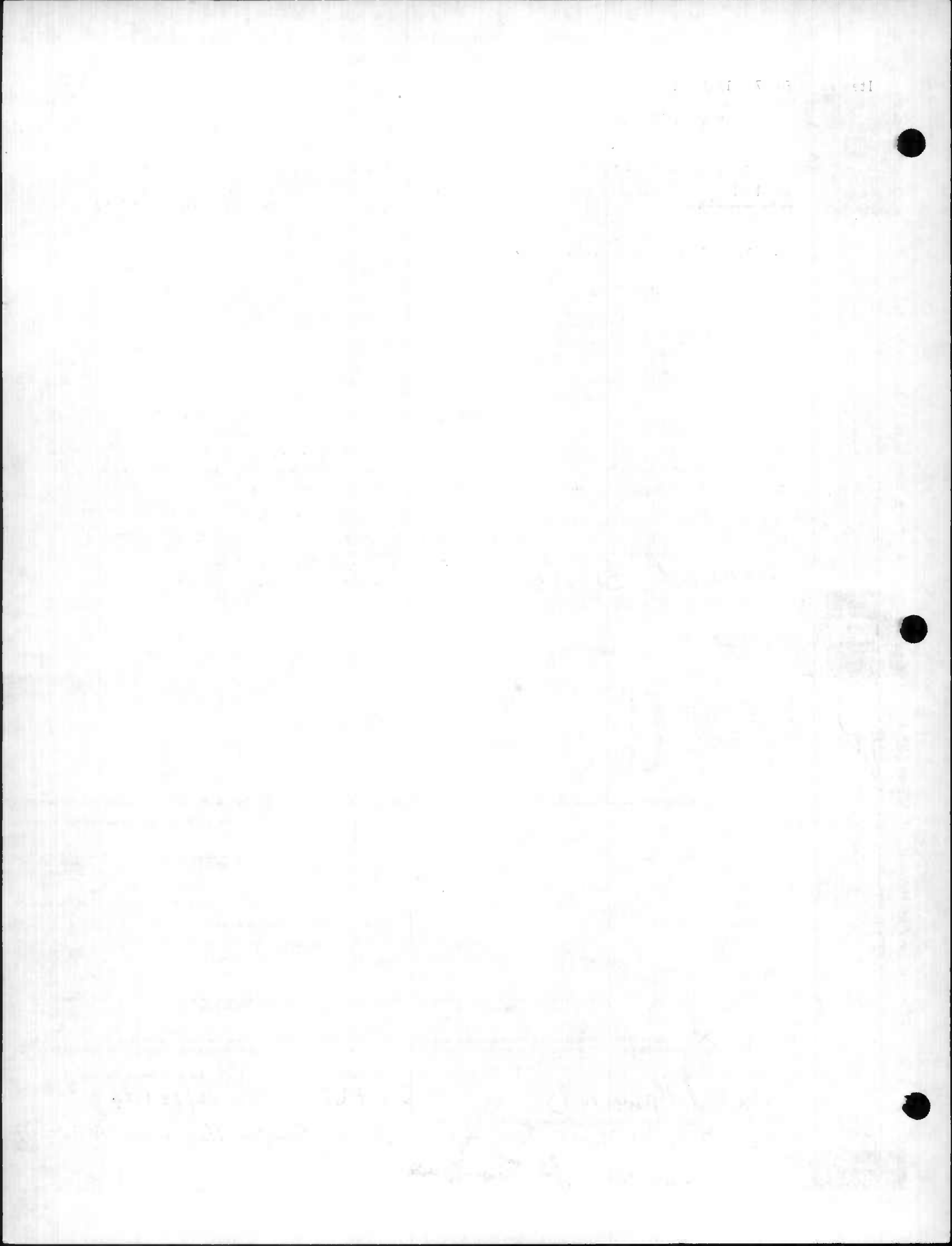
Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the funeral-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 39970

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Miriam

Truesdell

2. Date of Death

December 28, 1997

3. Time of Death

12:00 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Collington Episcopal Life Care

4b. City, Town, or Location of Death

Mitchellville

4c. County of Death

Prince George's

5. Social Security Number

223 40 0300

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 18, 1907

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2802 Autumn Chase Run

10f. Zip Code

21401

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Analyst

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Morris C. Barton

18. Mother's Name (First, Middle, Maiden Surname)

Effie Stribling

19a. Informant's Name/Relationship (Type, Print)

Miriam MacGregor Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2802 Autumn Chase Run Annapolis Md. 21401

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metropolitan Crematory

Date

Dec. 30, 1997

20c. Location - City or Town, State

Alexandria Virginia

21. Signature of Funeral Service Licensee

James R. Gorman

22. Name and Address of Facility

Robert E. Evans Funeral Home, Inc.

16000 Annapolis Rd. Bowie Maryland 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

Cardiac Arrest

1 Hour

e. Due to (or as a consequence of):

Arteriolosclerosis Coronary Artery Disease

30 Years

b. Due to (or as a consequence of):

c. Hypertension

50 Years

Due to (or as a consequence of):

d. Congestive Heart Failure

20 Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer, Dementia, Arthritis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mary Ruth M. Lopez

29c. License number

D 46834

29d. Date signed (Month, Day, Year)

December 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mary Ruth Lopez M.D. 7243 Hanover Parkway Greenbelt Maryland

31. Date filed (Month, Day, Year)

JAN 02 1998

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

87 39971

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Kathryn vonDrehle

2. Date of Death

Month Day Year  
December 31, 1997

3. Time of Death

4:10pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Crofton Convalescent Center

4b. City, Town, or Location of Death

Crofton

4c. County of Death

Anne Arundel

5. Social Security Number

217-22-1304

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

92

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 12, 1905

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Crofton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2131 Davidsonville Road

10f. Zip Code

21114

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Navar Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Design/Stylist

16b. Kind of Business/Industry

Textiles

17. Father's Name (First, Middle, Last)

Lawrence vonDrehle

18. Mother's Name (First, Middle, Maiden Surname)

Katherine Hodgson

19a. Informant's Name/Relationship (Type, Print)

Dale Eutsler - Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

307 8th Ave. S.E. Glen Burnie, MD 21061

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Cemetery

Data

1/3

20c. Location - City or Town, State

Glen Burnie, MD

21. Signature of Funeral Service Licensee

Kimberly S. Rowe

22. Name and Address of Facility

Hardesty Funeral Home, P.A.  
12 Ridgely Ave. Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Dementia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Howard K. Schutte Jr.

29c. License number

D35848

29d. Date signed (Month, Day, Year)

Jan 2, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Howard K. Schutte Jr. 1438 Defense Hwy Gambrills MD 21054

31. Date filed (Month, Day, Year)

JAN 02 1998

Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 39972

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |   |  |
|---|---|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Thomas J. Veystrk Jr.</b>  |  |   |  | 2. Date of Death<br>Month <b>December</b> Day <b>30</b> Year <b>97</b>   |  | 3. Time of Death<br><b>9:52AM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>V A Medical Center</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>N/A</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>213-12-3615</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 11, 1919</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>3804 Pinedale Drive</b>  |  | 10f. Zip Code<br><b>21236</b>  |  | 10g. Citizen of What Country?<br><b>U. S. A.</b>  |  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1941-1944</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th Grade</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Office Clerk</b>  |  | 16b. Kind of Business/Industry<br><b>U. S. Government</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>Thomas J. Veystrk Sr.</b>   |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary E. Hartman</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Thomas M. Veystrk (Nephew)</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3804 Pinedale Drive, Baltimore, Maryland 21236</b>                                       |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Sacred Heart of Jesus</b>  |  | 20c. Date<br><b>1/3/98</b>  |  | 20d. Location - City or Town, State<br><b>Baltimore, Maryland</b>  |  | 21. Signature of Funeral Service Licensee<br><b>Robert J. Podach</b>  |  |
|   | 22. Name and Address of Facility<br><b>Schimunek Funeral Home Inc.<br/>3331 Brehms Lane, Baltimore, Maryland 21213</b>  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>PARKINSON'S DISEASE</b>                                 |  | Approximate Interval Between Onset and Death<br><b>4 YEARS</b>   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                      |  |
| To Be Completed by Physician/Medical Examiner | 23c. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 23d. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Aortic Aneurysm</b>  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>   |  |
| To Be Completed by Physician/Medical Examiner | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>Dean E. Johnson MD</b>  |  | 29c. License number<br><b>D47635</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>December 30, 1997</b>   |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dean E. Johnson, MD 10 N. GREENE ST, BALTIMORE, MD 21201</b>   |  | 31. Date filed (Month, Day, Year)<br><b>JAN 02 1998</b>   |  | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>   |  | 33. Date of Death<br><b>December 30, 1997</b>   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 39973

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

|   |  |  |  |  |
|---|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>LARRY VEREEN</b>   |  | 2. Date of Death<br>Month <b>DEC.</b> Day <b>26</b> Year <b>1997</b> |  | 3. Time of Death<br><b>3:14am</b>                      |
| 4a. Facility Name (If not institution, give street and number)<br><b>UNIVERSITY OF MARYLAND MED. CTR.</b> |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>             |  | 4c. County of Death<br><b>N/A</b>                      |
| 5. Social Security Number<br><b>216-50-2220</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>48</b> Yrs.                     | 8. Date of Birth (Month, Day, Year)<br><b>Sept 9, 1949</b> | 9. Birthplace (State or Foreign Country)<br><b>SC.</b> |

Funeral  
Director

|  |                           |  |  |  |
|--|---------------------------|--|--|--|
| Usual Residence of Decedent  |                           | 10c. City, Town or Location<br><b>Baltimore</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
| 10e. State<br><b>MD</b>  | 10b. County<br><b>N/A</b> | 10f. Zip Code<br><b>21223</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |
| 10e. Street and Number<br><b>1071 West Lexington Street</b>  |                           | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>7/16/68</b><br><b>7/17/68</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc.<br><b>Black</b>   |                           | Specify:   |  |  |

To Be Completed by Funeral Director

|   |  |   |
|---|--|---|
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>Plummer</b> |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Cooling &amp; Heating</b> |
|---|--|---|

|   |  |
|---|--|
| 17. Father's Name (First, Middle, Last)<br><b>Emerson B. Vereen Sr.</b> | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Frankie Graham</b> |
|---|--|

|  |   |
|--|---|
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Audrey Lewis (Sister)</b> | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4 Suzanne Court Randallstown, Md. 21133</b> |
|--|---|

|   |  |                                     |
|---|--|-------------------------------------|
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garrison Forest Vet 12/30/97 Owings Mills, Md</b> | 20c. Location - City or Town, State |
|---|--|-------------------------------------|

|   |   |
|---|---|
| 21. Signature of Funeral Service Licensee<br> | 22. Name and Address of Facility<br><b>Cable Funeral Service<br/>5502 Winner Ave. Baltimore, Md 21215</b> |
|---|---|

Physician  
/Medical  
Examiner

|  |  |  |
|--|--|--|
| 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>MYOCARDIAL INFARCTION</b><br>Due to (or as a consequence of):<br><b>GASTROINTESTINAL BLEED</b><br>Due to (or as a consequence of):<br><b>HYPONATREMIA</b><br>Due to (or as a consequence of):<br><b>CORONARY ARTERY DISEASE</b> |  | Approximate Interval Between Onset and Death |
|--|--|--|

|  |  |
|--|--|
| Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
|--|--|

|   |  |
|---|--|
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
|---|--|

|   |   |
|---|---|
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
|---|---|

|  |  |                                 |   |                                   |
|--|--|---------------------------------|---|-----------------------------------|
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury<br><b>M</b> | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |                                 | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |                                   |

|   |   |                                      |   |
|---|---|--------------------------------------|---|
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | 29b. Signature and title of certifier<br> | 29c. License number<br><b>P09748</b> | 29d. Date signed (Month, Day, Year)<br><b>DEC. 26, 1997</b> |
|---|---|--------------------------------------|---|

|   |
|---|
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>STEPHEN L. LIN 22 S. GREENE ST. BALTIMORE MD 21201</b> |
|---|

|   |                               |
|---|-------------------------------|
| 31. Date filed (Month, Day, Year)<br><b>JAN 02 1998</b> | 32. Registrar's Signature<br> |
|---|-------------------------------|

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39974

|   |  |  |   |  |   |
|---|--|--|---|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>PARTHINIA WALKER</b>  |  | 2. Date of Death<br>Month <b>December</b> Day <b>22</b> , Year <b>1997</b>  |  | 3. Time of Death<br><b>13:14 PM</b>   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>THE JOHNS HOPKINS HOSPITAL</b>  |  | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>   |  | 4c. County of Death   |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-82-6607</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>36</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  |
|   | 8. Date of Birth (Month, Day, Year)<br><b>7/10/1961</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |   |
| To Be Completed by Funeral Director   | Usual Residence of Decedent  |  | 10a. State<br><b>MD.</b>  |  | 10b. County   |
|   | 10c. City, Town or Location<br><b>Baltimore City</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |
|   | 10e. Street and Number<br><b>1212 Appleland Ct.</b>  |  | 10f. Zip Code<br><b>21202</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+)  |  |   |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Security Guard</b>   |  | 16b. Kind of Business/Industry<br><b>Security</b>   |  |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>Fred. Woods</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Clarice Walker</b>  |  |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Clarice Walker</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1020 Druid H. Ave. Bkmt. Md. 21217</b>  |  |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                      |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Wt. 2:00 Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore County, Md.</b>   |
|   | 21. Signature of Funeral Service Licensee<br><b>[Signature]</b>  |  | 22. Name and Address of Facility<br><b>Wm. Carroll Funeral Home<br/>1712 W. North Ave, Bkmt. Md. 21217</b>  |  |   |
| Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  | Approximate Interval Between Onset and Death  |
|   | Immediate Cause (Final disease or condition resulting in death)<br>a. <b>SEPSIS</b><br>Due to (or as a consequence of):<br>b. <b>ISCHEMIC BOWEL</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.                                    |  |   |  | <b>9 DAYS</b><br><br><b>27 DAYS</b>   |
| To Be Completed by Physician/Medical Examiner   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
|   | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |
| 29b. Signature and title of certifier<br><b>[Signature] MD</b>  |  | 29c. License number<br><b>RES-000</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>December 22, 1997</b>                        |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Tain-Yen Hsia, MD THE JOHNS HOPKINS HOSPITAL, BALTIMORE, MD.</b> |  |  |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>JAN 02 1998</b>   |  | 32. Registrar's Signature<br><b>[Signature]</b>  |   |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39975

|  |   |  |   |  |  |  |  |   |   |  |   |                               |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |
|--|---|--|---|--|--|--|--|---|---|--|---|-------------------------------|--|--|--|--|--|--|--|---|----------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|----------------------------------|--|--|--|--|--|--|--|----|--|--|--|--|--|--|--|----------------------------------|--|----|--|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>Phillip I. White, Jr</b>   |  |   |  |  |  | 2. Date of Death<br>Month <b>Dec.</b> Day <b>27</b> Year <b>1997</b>   |   | 3. Time of Death<br><b>1:18 AM</b>  |  |   |                               |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>1436 Presstman Street</b>  |  |   |  |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |   | 4c. County of Death<br><b>NA</b>  |  |   |                               |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-40-4082</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>56</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 24, 1941</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |  |   |                               |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |
|  | Usual Residence of Decedent   |  |   |  |  |  |  |   |   |  |   |                               |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |
| To Be Completed by Funeral Director                                  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>NA</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |                               |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |
|  | 10e. Street and Number<br><b>1436 Presstman Street</b>  |  |   |  | 10f. Zip Code<br><b>21217</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |   |  |   |                               |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |   |  |   |                               |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>11th</b>   |  | College (1-4 or 5+)<br><b>NA</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Longshoreman</b>   |  |  | 16b. Kind of Business/Industry<br><b>MD. Port Auth.</b>                 |   |  |   |                               |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Phillip I. White Sr.</b>  |  |   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Myrtle Hall</b>  |   |   |  |   |                               |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |
| Physician<br>/Medical<br>Examiner                                    | 19a. Informant's Name/Relationship (Type, Print)<br><b>Maggie R. White - Wife</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1436 Presstman St. Balto. Md. 21217</b>  |  |  |   |   |  |   |                               |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Carpenter Hill Cem.</b>   |  | Date<br><b>12/31/97</b>  |   | 20c. Location - City or Town, State<br><b>Severna Park, Md</b>  |  |   |                               |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Whit Edmond</b>   |  |   |  | 22. Name and Address of Facility<br><b>Wm. C. March Funeral Home West Inc<br/>4300 Wabash Ave Balto. Md 21215</b>  |  |  |   |   |  |   |                               |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |  |  |  |   |   |  |   |                               |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |
|  | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td colspan="8">a. <b>Respiratory Failure</b></td> <td rowspan="4">Approximate Interval Between Onset and Death<br/><b>minute</b></td> </tr> <tr> <td colspan="8">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td colspan="8">b. <b>metastatic Esophageal cancer</b></td> </tr> <tr> <td colspan="8">Due to (or as a consequence of):</td> </tr> <tr> <td colspan="8">c.</td> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td colspan="8">d.</td> <td colspan="2"></td> </tr> </table> |  |   |  |  |  |  |   |   |  | Immediate Cause (Final disease or condition resulting in death) | a. <b>Respiratory Failure</b> |  |  |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>minute</b> | Due to (or as a consequence of): |  |  |  |  |  |  |  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. <b>metastatic Esophageal cancer</b> |  |  |  |  |  |  |  | Due to (or as a consequence of): |  |  |  |  |  |  |  | c. |  |  |  |  |  |  |  | Due to (or as a consequence of): |  | d. |  |  |  |  |  |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)      | a. <b>Respiratory Failure</b>   |  |   |  |  |  |  |   | Approximate Interval Between Onset and Death<br><b>minute</b>   |  |   |                               |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |
|  | Due to (or as a consequence of):  |  |   |  |  |  |  |   |   |  |   |                               |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |
|  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | b. <b>metastatic Esophageal cancer</b> |   |  |  |  |  |   |   |  |   |                               |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |
|  |   | Due to (or as a consequence of):       |   |  |  |  |  |   |   |  |   |                               |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |
| c.   |   |  |   |  |  |  |  | Due to (or as a consequence of):  |   |  |   |                               |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |
| d.   |   |  |   |  |  |  |  |   |   |  |   |                               |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |   |  |   |                               |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |
|  |   |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |   |                               |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |   |   |  |   |                               |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred   |  |   |                               |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |
|  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |   |   |  |   |                               |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |
| State<br>Registrar   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br><b>M.D.</b>  |  | 29c. License number<br><b>D44944</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>12/29/97</b>   |   |   |  |   |                               |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |
|  | 30. Name and address of person who completed cause of death (item 23a) (Type, Print)<br><b>Stanley Walker Union Memorial Hosp. &amp; Baltimore Md.</b>  |  |   |  |  |  |  |   |   |  |   |                               |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |
|  | 31. Date filed (Month, Day, Year)<br><b>JAN 09 1998</b>   |  | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>  |  |  |  |  |   |   |  |   |                               |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |
|  |   |  |   |  |  |  |  |   |   |  |   |                               |  |  |  |  |  |  |  |   |                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39976

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY HELEN WADE

2. Date of Death

DEC. 26, 1997

3. Time of Death

5:00 pm

4a. Facility Name (If not institution, give street and number)

7100 ROLLING BEND ROAD (res.)

4b. City, Town, or Location of Death

WOODLAWN

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

216-34-9632

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

58

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

05/28/1939

9. Birthplace (State or Foreign Country)

W. Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

WOODLAWN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7100 ROLLING BEND ROAD

10f. Zip Code

21207

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16e. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Housekeeping

16b. Kind of Business/Industry

Town & Country  
Apartments

17. Father's Name (First, Middle, Last)

Sidney Wade

18. Mother's Name (First, Middle, Maiden Surname)

Thelma Wade

19a. Informant's Name/Relationship (Type, Print)

Gregory Wade

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4511 Kenilworth Avenue, Balto., MD 21212

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Arbutus Memorial Park 12/31/97 Arbutus, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Leroy O. Dyett

22. Name and Address of Facility

LEROY O. DYETT & SON FUNERAL HOME, P.A.  
4600 LIBERTY HEIGHTS AVE., BALTO. MD 2120723a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

myocardial infarction

Due to (or as a consequence of):

b.

hypertensive cardiovascular disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

asthma

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of causa  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Bernita C. Taylor MD

29c. License number

033212

29d. Date signed (Month, Day, Year)

12/30/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bernita C. Taylor MD 1113 N Rolling Rd Catonsville Md 21228

31. Date filed (Month, Day, Year)

JAN 02 1998

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended #28a per Phy G755 1/7/98 EW

## Certificate of Death

Reg. No.

97 39977

|   |   |   |   |  |  |  |   |  |
|---|---|---|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedant's Name (First, Middle, Last)<br><b>Kenneth Young</b>  |   |   |  | 2. Date of Death<br>Month <b>Dec</b> Day <b>23</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>11:28</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>University of Maryland</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>Baltimore</b>                                 |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>321 42 2858</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>50</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>11-19-1947</b>                | 9. Birthplace (State or Foreign Country)<br><b>Ill</b> |
|   | Usual Residence of Decedant   |   |   |  |  |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>   | 10b. County<br><b>NA</b>  | 10c. City, Town or Location<br><b>Baltimore</b>   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
|   | 10e. Street and Number<br><b>506 Cathedral Street</b>   |   |   |  | 10f. Zip Code<br><b>21201</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A</b>                           |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>Korean</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th grade</b><br>College (1-4 or 5+) <b>3 yrs</b>  |   | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Self Employed</b>                               |  | 16b. Kind of Business/Industry<br><b>Entertainment</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner   | 17. Father's Name (First, Middle, Last)<br><b>Cleophus G. Young</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lavern Chew</b>  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Minyette Young - Daughter</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7102 Buford Ct Apt 202 Baltimore md 21244</b>  |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>King Memorial Park</b>   |  | 20c. Location - City or Town, State<br><b>12-29-97 Randallstown, md</b>  |  |   |  |
|   | 21. Signature of Funeral Service Licensee<br><b>John B. Johnson</b>   |   | 22. Name and Address of Facility<br><b>March F.H. West<br/>4300 Wabash Avenue Balto md 21205</b>  |  |  |  |   |  |
| Physician<br>/Medical<br>Examiner   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                             |   |   |  |  |  |   |  |
|   | Immediate Cause (Final disease or condition resulting in death)<br><b>a. Myocardial Infarction</b>  |   |   |  |  |  |   |  |
|   | Due to (or as a consequence of):<br><b>b. Hypertension</b>  |   |   |  |  |  |   |  |
|   | Due to (or as a consequence of):<br><b>c. End stage Renal Disease</b>   |   |   |  |  |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>d.</b>   |   |   |   |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |  |  |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |   |   |   |  |  |  |   |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |   |  |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)<br><b>Dec 23 97</b>  |   | 28b. Time of Injury<br><b>M</b>                  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   | 28d. Describe how injury occurred                      |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><b>Brian Broome MD</b>   |   | 29c. License number<br><b>032532</b>             |  | 29d. Date signed (Month, Day, Year)<br><b>Dec 23 1997</b>                                      |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>BRIAN J. BROOME 225 Greene Street Balto, md 21201</b>  |   |   |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JAN 02 1998</b>   |   | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>  |   |  |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



97 39978

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>GOLDIE E. ADAMS</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>DEC 18 1997</b>  |  | 3. TIME OF DEATH<br>M<br><b>0835</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-74-3139</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>86</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>FEB 19, 1911</b>                           |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>PENNSYLVANIA</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>ALLEGANY COUNTY NURSING HOME</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>CUMBERLAND</b>                             |  |
| 9c. COUNTY OF DEATH<br><b>ALLEGANY</b>   |  |  |  | 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY<br><b>ALLEGANY</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>CUMBERLAND</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 10e. STREET AND NUMBER<br><b>481 EASTERN AVENUE</b>  |  |  |  | 10f. ZIP CODE<br><b>21502</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>           |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b>  |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOMEMAKER</b>   |  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>OWN HOME</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>SHANNON RUBY</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>VIOLA UNKNOWN</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>SCIP RODEHEAVER, GRANDDAUGHTER</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>481 EASTERN AVE., CUMBERLAND, MD 21502</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>SUNSET MEMORIAL PARK</b>   |  | 20c. LOCATION — City or Town, State<br><b>23, 1997 CUMBERLAND, MD</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Douglas A. Hafner</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>HAFTER CHAPEL OF THE HILLS MORTUARY<br/>1302 NATIONAL HWY, LAVALE, MD 21502</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. <i>Carcinoma of Uterus</i><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  | Approximate Interval Between Onset and Death<br><b>6 mos</b>                         |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  | b. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |
|  |  | c. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |
|  |  | d. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Coronary Artery Disease</i>   |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)         |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>R. Barrera</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D-14865</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>DEC 22, 1997</b>                           |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DR. R. BARRERA, MEMORIAL HOSPITAL MEDICAL BLDG., CUMBERLAND, MD 21502</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>DEC 23 1997</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John D. ...</i>   |  |  |  |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39979

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Bill

Willard

Anderson

2. Date of Death

Month

Day

Year

DECEMBER 8, 1997

3. Time of Death

0235

4a. Facility Name (If not institution, give street and number)

Union Hospital

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

5. Social Security Number

415-03-5880

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85

8. Date of Birth

4-16-1912

9. Birthplace (State or Foreign Country)

Harlan Cty., KY

Usual Residence of Decedent

10a. State

Delaware

10b. County

New Castle

10c. City, Town or Location

Newark

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2644 Frazer Road

10f. Zip Code

19702

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 7-5-27 to 5-19-43

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Freight Conductor

16b. Kind of Business/Industry

Railroad

17. Father's Name (First, Middle, Last)

William Anderson

18. Mother's Name (First, Middle, Maiden Surname)

Jenny Hanby

19a. Informant's Name/Relationship (Type, Print)

Joy L. Anderson/Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2644 Frazer Road, Newark, DE 19702

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Delaware Veterans Memorial Cemetery

Date

12-9-97

20c. Location - City or Town, State

Bear, Delaware

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Beeson Memorial Services

2053 Pulaski Highway, Newark, DE 19702

23a. Part I. Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Aspiration Pneumonia

Due to (or as a consequence of):

c. Metastatic Esophageal Cancer

Due to (or as a consequence of):

Approximate interval between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Malnutrition

COPD

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

830291

29d. Date signed (Month, Day, Year)

12/1/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert DeNitzro, MD, 111 West High Street, Suite 310, Elkton, MD 21921

31. Date filed (Month, Day, Year)

DEC 10 1997

32. Registrar's Signature

State

Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760, ANDERSON, BILL

10 x 1 1/4



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39980

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MINA ELIZABETH ALCORN

2. Date of Death

Month Day Year  
DEC. 9, 1997

3. Time of Death

5:46 pm

Funeral  
Director

4a. Facility Name (If not Institution, give street and number)

Medpointe Continuing Care Facility

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

5. Social Security Number

221-09-0136

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug 18 1914

9. Birthplace (State or Foreign Country)

Delaware

Usual Residence of Decedent

10a. State

MD

10b. County

Cecil

10c. City, Town or Location

Elkton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

128 Bowling La. Thomson Ests.

10f. Zip Code

21921

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

home

17. Father's Name (First, Middle, Last)

Howard Blades

18. Mother's Name (First, Middle, Maiden Summa)

Lily Scott

19a. Informant's Name/Relationship (Type, Print)

Robert Alcorn (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

128 Bowling La. Elkton, MD 21921

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Barratts Chapel

Date

12/13/97

20c. Location - City or Town, State

Frederica, DE

21. Signature of Funeral Service Licensee

M00510

22. Name and Address of Facility

Galena Funeral Home of Stephen L. Schaech  
Box 235 118 W. Cross St. Galena, MD 2163523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. ATRIAL FIBRILLATION

Due to (or as a consequence of):

1 mo.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

2 yrs.

c. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

5 yrs.

d. ANGINA OF CHRONIC DISEASE

Due to (or as a consequence of):

1 yr.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending  
Investigation 6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?M 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Rolando A. Najera MD

29c. License number

D07463

29d. Date signed (Month, Day, Year)

12-10-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rolando A. Najera MD 118 North St. Elkton, MD 21921

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 11 1997

32. Registrar's Signature

Julia Anderson-Randall

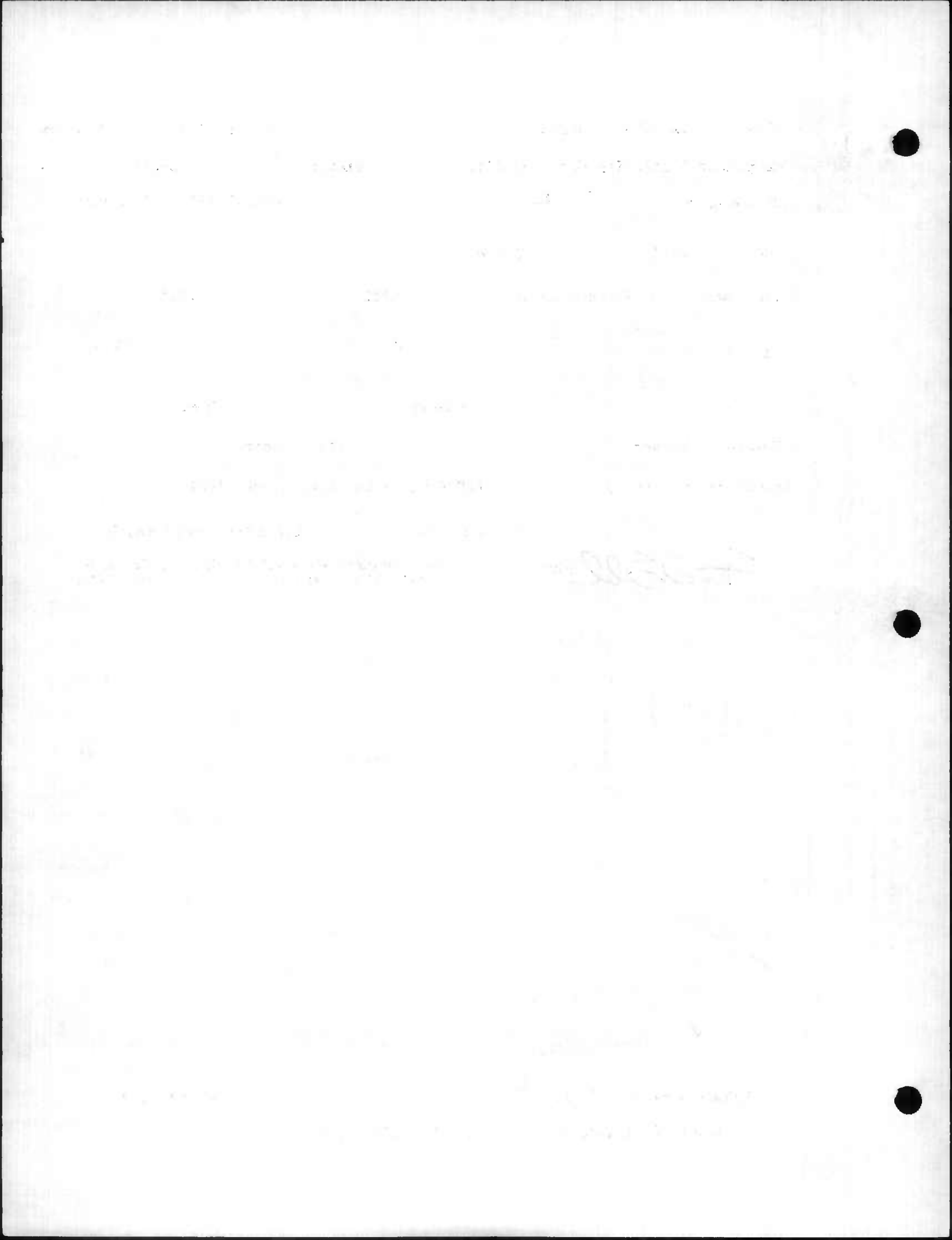
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39981

Physician  
/Medical  
Examiner

Funeral  
Director

|  |  |   |  |  |                                |  |  |
|--|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Sara Adelaide Allston</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>Dec. 17, 1997</b>   |                                | 3. Time of Death<br><b>07:20AM</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Memorial Hospital at Easton</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Easton, MD</b>  |                                | 4c. County of Death<br><b>Talbot</b>   |  |
| 5. Social Security Number<br><b>213-18-5710</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>October 4, 1921</b>                                    |  |
| 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |   |  |  |                                |  |  |
| Usual Residence of Decedent  |  |   |  |  |                                |  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Caroline</b>  |  | 10c. City, Town or Location<br><b>Federalsburg</b>   |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>2004 University Apartments Drive</b>  |  |   |  | 10f. Zip Code<br><b>21632</b>  |                                | 10g. Citizen of What Country?<br><b>United States</b>  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify:<br><b>Caucasian</b>                   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11 HS Grad.</b><br>College (1-4 or 5+) <b>College</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Sales Clerk</b>  |                                | 16b. Kind of Business/Industry<br><b>Department Stores</b>                                       |  |
| 17. Father's Name (First, Middle, Last)<br><b>Robert Bruce Finn</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lulu Elizabeth Turner</b>  |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Joanne Willis Daughter</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4566 American Corner Road, Federalsburg, MD 21632</b>  |                                |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Denton Cemetery</b>  |  | Date<br><b>12/20</b>   |                                | 20c. Location - City or Town, State<br><b>Denton, Maryland</b>                                   |  |
| 21. Signature of Funeral Service Licensee<br><b>► Randolph Moore</b>   |  |   |  | 22. Name and Address of Facility<br><b>Moore Funeral Home, P.A.<br/>12 South Second Street, Denton, Maryland 21629</b>   |                                |  |  |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Acute pulmonary edema</b><br>Due to (or as a consequence of):<br>b. <b>Ischemic cardiomyopathy</b><br>Due to (or as a consequence of):<br>c. <b>Coronary Artery Disease</b><br>Due to (or as a consequence of):<br>d. <b>Insulin Dependent Diabetes</b><br>Approximate Interval Between Onset and Death<br><b>12 days</b><br><b>years</b><br><b>years</b><br><b>years</b> |  |   |  |  |                                |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cellulitis Both Shins</b><br><b>Acute renal insufficiency</b><br><b>hypertension</b>  |  |   |  |  |                                |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |   |  |  |                                |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |                                |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |                                |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No             |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28d. Describe how injury occurred  |                                |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |                                |  |  |
| 29a. Certifier (Check only one)<br>2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |                                |  |  |
| 29b. Signature and title of certifier<br><b>► Michael E. Lees</b>  |  |   |  | 29c. License number<br><b>D42005</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>12/17/97</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Michael E. Lees, 606 Dutchmen's Lane, Easton, Maryland 21601</b>  |  |   |  |  |                                |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 17 '97</b>   |  |   |  | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>   |                                |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Allston, Sara Finn



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 97 39982

|   |  |  |   |                                |  |  |  |  |   |                                       |  |                                  |    |
|---|--|--|---|--------------------------------|--|--|--|--|---|---------------------------------------|--|----------------------------------|----|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Mary Helen Bowman  |  |   |                                | 2. Date of Death<br>Month Day Year<br>12 16 97   |  | 3. Time of Death<br>9:50 AM                                      |  |   |                                       |  |                                  |    |
|   | 4a. Facility Name (If not institution, give street and number)<br>Carroll County General Hospital  |  |   |                                | 4b. City, Town, or Location of Death<br>Westminster  |  | 4c. County of Death<br>Carroll                                   |  |   |                                       |  |                                  |    |
| Funeral<br>Director   | 5. Social Security Number<br>220-36-9026   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br>92 Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>Nov. 25, 1905   | 9. Birthplace (State or Foreign Country)<br>Maryland             |  |   |                                       |  |                                  |    |
|   | Usual Residence of Decedent  |  |   |                                |  |  |  |  |   |                                       |  |                                  |    |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland   | 10b. County<br>Carroll   | 10c. City, Town or Location<br>Union Bridge   |                                |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |   |                                       |  |                                  |    |
|   | 10e. Street and Number<br>24 S. Main St.   |  |   | 10f. Zip Code<br>21791         |  | 10g. Citizen of What Country?<br>U.S.A.  |  |  |   |                                       |  |                                  |    |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |   |                                       |  |                                  |    |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11 College (1-4or 5+) 4   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>School Teacher                       |                                | 16b. Kind of Business/Industry<br>Public Schools   |  |  |  |   |                                       |  |                                  |    |
|   | 17. Father's Name (First, Middle, Last)<br>Joseph U. Baker   |  |   |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary O. Watt  |  |  |  |   |                                       |  |                                  |    |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>Dr. J. Fred Baker/nephew   |  |   |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>119 Record St. Unit 3 Frederick, Md. 21701  |  |  |  |   |                                       |  |                                  |    |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Carroll Cremation Inc.  |                                | Date<br>12/17/97   |  | 20c. Location - City or Town, State<br>Hampstead, Md.            |  |   |                                       |  |                                  |    |
|   | 21. Signature of Funeral Service Licensee<br><i>Catherine O. Varbler</i>   |  |   |                                | 22. Name and Address of Facility<br>Hartzler Funeral Home<br>6 E. Broadway Union Bridge, Md. 21791   |  |  |  |   |                                       |  |                                  |    |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |                                |  |  |  |  |   |                                       |  |                                  |    |
|   | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <i>Acute myocardial infarction</i></td> <td rowspan="4">Approximate Interval Between Onset and Death<br/><i>Minutes</i></td> </tr> <tr> <td>b. <i>Coronary heart disease</i></td> </tr> <tr> <td>c.</td> </tr> <tr> <td>d.</td> </tr> </table> |  |   |                                |  |  |  |  | Immediate Cause (Final disease or condition resulting in death) | a. <i>Acute myocardial infarction</i> | Approximate Interval Between Onset and Death<br><i>Minutes</i> | b. <i>Coronary heart disease</i> | c. |
| Immediate Cause (Final disease or condition resulting in death)   | a. <i>Acute myocardial infarction</i>  | Approximate Interval Between Onset and Death<br><i>Minutes</i>   |   |                                |  |  |  |  |   |                                       |  |                                  |    |
|   | b. <i>Coronary heart disease</i>   |  |   |                                |  |  |  |  |   |                                       |  |                                  |    |
|   | c.   |  |   |                                |  |  |  |  |   |                                       |  |                                  |    |
|   | d.   |  |   |                                |  |  |  |  |   |                                       |  |                                  |    |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Lymphoma - Bone Marrow</i><br><i>Bicuspid aortic valve</i>   |  |  |   |                                |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |   |                                       |  |                                  |    |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |                                |  |  |  |  |   |                                       |  |                                  |    |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |                                |  |  |  |  |   |                                       |  |                                  |    |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br>M       |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |                                       |  |                                  |    |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how Injury occurred  |   |                                |  |  |  |  |   |                                       |  |                                  |    |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |                                |  |  |  |  |   |                                       |  |                                  |    |
| 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |                                |  |  |  |  |   |                                       |  |                                  |    |
| 29b. Signature and title of certifier<br><i>J. H. Caricofe MD</i>   |  |  |   | 29c. License number<br>D 906   |  | 29d. Date signed (Month, Day, Year)<br>12/16/97  |  |  |   |                                       |  |                                  |    |
| 30. Name and address of person who completed cause of death (Item 23b) (Type, Print)<br><i>J. H. Caricofe MD, P.O. Box 1110 Union Bridge Md 21791</i>   |  |  |   |                                |  |  |  |  |   |                                       |  |                                  |    |
| 31. Date (Month, Day, Year)<br>DEC 18 1997  |  | 32. Registrar's Signature<br><i>Julie Duckworth-Randall</i>  |   |                                |  |  |  |  |   |                                       |  |                                  |    |

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39983

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY

ELIZABETH

BANKS

2. Date of Death

Month Day Year  
DEC. 20 1997

3. Time of Death

8:35 a.m.

4a. Facility Name (If not Institution, give street and number)

PHYSICIANS MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

LA PLATA

4c. County of Death

CHARLES

Funeral  
Director

5. Social Security Number

246-10-2784

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
OCTOBER 16, 1918

9. Birthplace (State or Foreign Country)

NORTH CAROLINA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

CHARLES

10c. City, Town or Location

LA PLATA

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

16 PARTRIDGE COURT

10f. Zip Code

20646

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Collega (1-4 or 5+)

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

OPERATOR/OWNER

16b. Kind of Business/Industry

RESTAURANT

17. Father's Name (First, Middle, Last)

JAMES CLAUDE THOMASON

18. Mother's Name (First, Middle, Maiden Summa)

MARY NANCY AUTEN

19a. Informant's Name/Relationship (Type, Print)

SHIRLEY S. BARNETT/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16 PARTRIDGE COURT, LA PLATA, MARYLAND 20646

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

PARK HILL CEMETERY

Date

DEC 24, 1997

20c. Location - City or Town, State

MARBURY, MARYLAND

21. Signature of Funeral Service Licensee

MARK G. BROHAWN

M00053

22. Name and Address of Facility

THE HUNTT FUNERAL HOME, INC.

P. O. BOX 156, WALDORF, MARYLAND 20604

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

e. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

CVA - Strokes

HTN

Heart Disease

DM

Approximate Interval Between Onset and Death

Weeks

yrs

yrs

yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home

5 ☐ Residence

8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Attending physician

29c. License number

D-47849

29d. Date signed (Month, Day, Year)

12-20-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MONIKA LEE M.D. 700 OLD LINE CENTER SUITE 100 WALDORF MARYLAND 20602

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

Julia Anderson-Rodwell

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39984

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARGUERITE VIRGINIA BAICAR

2. Date of Death

Month Day Year  
DECEMBER 19, 1997

3. Time of Death

7:35 PM

4a. Facility Name (If not institution, give street and number)

WALDORF HEALTH CARE CENTER

4b. City, Town, or Location of Death

WALDORF

4c. County of Death

CHARLES

Funeral  
Director

5. Social Security Number

579-38-9787

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JULY 10, 1911

9. Birthplace (State or Foreign Country)

GEORGIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

CHARLES

10c. City, Town or Location

LA PLATA

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

506 CLARKS RUN ROAD

10f. Zip Code

20646

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married

☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ADMINISTRATIVE ASSISTANT

16b. Kind of Business/Industry

U. S. GOVERNMENT

17. Father's Name (First, Middle, Last)

JOEL ANDERSON HADEN

18. Mother's Name (First, Middle, Maiden Surname)

FLORENCE ALMA ROSS

19a. Informant's Name/Relationship (Type, Print)

SALLIE D. WRIGHT/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

506 CLARKS RUN ROAD, LA PLATA, MARYLAND 20646

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State

☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

TRINITY MEMORIAL GARDENS

Date

DEC. 23, 1997

20c. Location - City or Town, State

WALDORF, MARYLAND

21. Signature of Funeral Home Licensee

MARK G. BROHAWN MO0053

22. Name and Address of Facility

THE HUNTT FUNERAL HOME, INC.

P.O. BOX 156, WALDORF, MARYLAND 20604

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Pneumonia

Approximate Interval Between Onset and Death

days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation

☐ Accident

☐ Suicide

☐ Homicide

☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D46419

29d. Date signed (Month, Day, Year)

12/20/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHARLENE A. LETCHFORD, M.D. 404 E. CHARLES ST LA PLATA, MD 20646

31. Date filed (Month, Day, Year)

DEC 23 1997

32. Registrar's Signature

[Signature]

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



|  |   |  |   |  |   |  |  |
|--|---|--|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>Russell Julius Broadwater</b>  |  |   |  | 2. Date of Death<br>Month <b>DECEMBER</b> Day <b>18</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>1615</b>  |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>Sacred Heart Hospital</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Cumberland</b>   |  | 4c. County of Death<br><b>Allegany</b>   |
| Funeral<br>Director  | 5. Social Security Number<br><b>215-36-9869</b>   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>68</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth<br>(Month, Day, Year)<br><b>28-JUL-29-</b><br><b>July 28, 1929</b>                | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                          |
|  | Usual Residence of Decedent   |  |   |  |   |  |  |
| To Be Completed by Funeral Director                                  | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Allegany</b>   | 10c. City, Town or Location<br><b>Frostburg</b>   |  |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|  | 10e. Street and Number<br><b>51 Victoria Lane</b>   |  |   | 10f. Zip Code<br><b>21532-</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>              |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Sergeant First Class</b>           |   | 16b. Kind of Business/Industry<br><b>United States Army</b>  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>James Albert Broadwater</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Martha Catherine Platter</b>  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Leona Broadwater Wife</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>51 Victoria Lane Frostburg Maryland 21532-</b> |   |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Frostburg Memorial Park</b>  |  | Date<br><b>21-Dec-97</b>  | 20c. Location - City or Town, State<br><b>Frostburg, Maryland</b>                                  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>John R. Durst</i>   |  |   | 22. Name and Address of Facility<br><b>Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532</b>  |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. METASTATIC CARCINOMA LUNG</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>f. CHRONIC OBSTRUCTIVE LUNG DISEASE</b><br>Due to (or as a consequence of):<br><br>Approximate Interval Between Onset and Death<br><b>16 months</b> |  |   |  |   |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CARCINOMA OF PHARYNX</b><br><b>CHRONIC OBSTRUCTIVE LUNG DISEASE</b>  |  |   |  |   |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |  |   |  |  |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No        |   |  |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |   |  |  |
|  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |   |  |   |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28d. Describe how injury occurred   |  |  |
|  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |  |
|  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |   |  |  |
|  | 29b. Signature and title of certifier<br><i>H Seidner</i>   |  |   | 29c. License number<br><b>D26907</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>DECEMBER 19, 1997</b>                                    |  |
|  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>SIDHU, HARJIT, M.D. 925 BISHOP WALSH ROAD CUMBERLAND, MD. 21502</b>  |  |   |  |   |  |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br><b>DEC 22 1997</b>   |  | 32. Registrar's Signature<br><i>John Durst</i>  |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 39986  
Certificate of Death

Reg. No.

|   |   |  |   |   |   |  |  |  |
|---|---|--|---|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Joseph F. Baker</b>  |  |   |   | 2. Date of Death<br>Month <b>December</b> Day <b>15</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>11:25 PM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Harford Memorial Hospital</b>  |  |   |   | 4b. City, Town, or Location of Death<br><b>Havre de Grace</b>   |  | 4c. County of Death<br><b>Harford</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>213-05-9338</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>July 14 1913</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Cecil</b>   |  | 10c. City, Town or Location<br><b>Conowingo</b>  |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent<br><b>521 Bell Manor Rd.</b>  |  | 10f. Zip Code<br><b>21918</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)   |  | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Welder</b>  |   | 16b. Kind of Business/Industry<br><b>Fabrication</b>  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>unknown</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>unknown</b>   |   |   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Isabelle Baker/Wife</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>521 Bell Manor Rd. Conowingo, MD 21918</b>  |   |   |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holy Redeemer Cemetery</b>   |   | 20c. Location - City or Town, State<br><b>12-18-97 Baltimore, Maryland</b>  |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>R. T. Foard Funeral Home<br/>111 S. Queen St. Rising Sun, MD 21911</b>   |   |   |  |  |  |
|   | 23a. Part I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Cerebrovascular accident</b><br>Due to (or as a consequence of):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Possible Aspiration Pneumonia</b><br>Due to (or as a consequence of):<br><b>Congestive heart failure</b><br>Due to (or as a consequence of): |  |   |   |   |  | Approximate Interval Between Onset and Death<br><b>2-3 days</b><br><b>1-2 days</b><br><b>1-2 days</b>  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)   |  |
|   |   | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred                      |  |  |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><b>Fahed Kouli MD</b>                         |   | 29c. License number<br><b>D48271</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>12/16/97</b> |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Kouli 319 S. Union Ave. Havre de Grace, MD 21078</b>   |   | 31. Date filed (Month, Day, Year)<br><b>DEC 17 1997</b>                                |   | 32. Registrar's Signature<br><b>John Davidson-Rendell</b>                                   |   |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39987

|  |  |  |   |  |  |  |  |  |
|--|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><i>Helen Breza</i>   |  |   |  | 2. Date of Death<br>Month <i>Dec</i> Day <i>22</i> Year <i>1997</i>  |  | 3. Time of Death<br><i>0300</i>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>96 Basil Ave</i>  |  |   |  | 4b. City, Town, or Location of Death<br><i>Chesapeake City</i>   |  | 4c. County of Death<br><i>Cecil</i>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><i>236-22-8447</i>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><i>82</i> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><i>Feb 4 1915</i>   |  |
|  | 9. Birthplace (State or Foreign Country)<br><i>West Virginia</i>   |  | 10a. State<br><i>MD</i>   |  | 10b. County<br><i>Cecil</i>  |  | 10c. City, Town or Location<br><i>Chesapeake City</i>  |  |
| To Be Completed by Funeral Director                                  | Usual Residence of Decedent  |  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |
|  | 10e. Street and Number<br><i>96 Basil Ave</i>  |  |   |  | 10f. Zip Code<br><i>21915</i>  |  | 10g. Citizen of What Country?<br><i>USA</i>  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i>  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Homemaker</i>   |  | 16b. Kind of Business/Industry<br><i>Own Home</i>  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><i>Thomas L. Boothe</i>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Hazel Unknown</i>  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><i>Paul Breza, husband</i>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>96 Basil Ave Chesapeake City MD 21915</i>  |  |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>R A Ferris December 22, 1997</i>   |  | 20c. Location - City or Town, State<br><i>West Chester PA</i>  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  | 22. Name and Address of Facility<br><i>R T Foard Funeral Home, P.A.<br/>318 George St. Chesapeake City MD 21915</i>   |  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><i>a. Metastatic Stomach CA</i><br>Due to (or as a consequence of):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><i>b. Due to (or as a consequence of):</i><br><i>c. Due to (or as a consequence of):</i><br><i>d. Due to (or as a consequence of):</i> |  |   |  |  |  | Approximate Interval Between Onset and Death<br><i>6 mos.</i>  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  |  |  |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
|  |  |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><i>M</i>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
|  | 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br><i>Fredrick Bantson</i>  |  | 29c. License number<br><i>047561</i>   |  | 29d. Date signed (Month, Day, Year)<br><i>12/22/97</i>   |  |
|  | 30. Name and address of person who completed cause of death (Item 28a) (Type/Print)<br><i>111 W. High St. Elkton MD 21921</i>  |  |   |  |  |  |  |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br><i>DEC 22 1997</i>  |  | 32. Registrar's Signature<br><i>Julia Anderson-Randall</i>  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

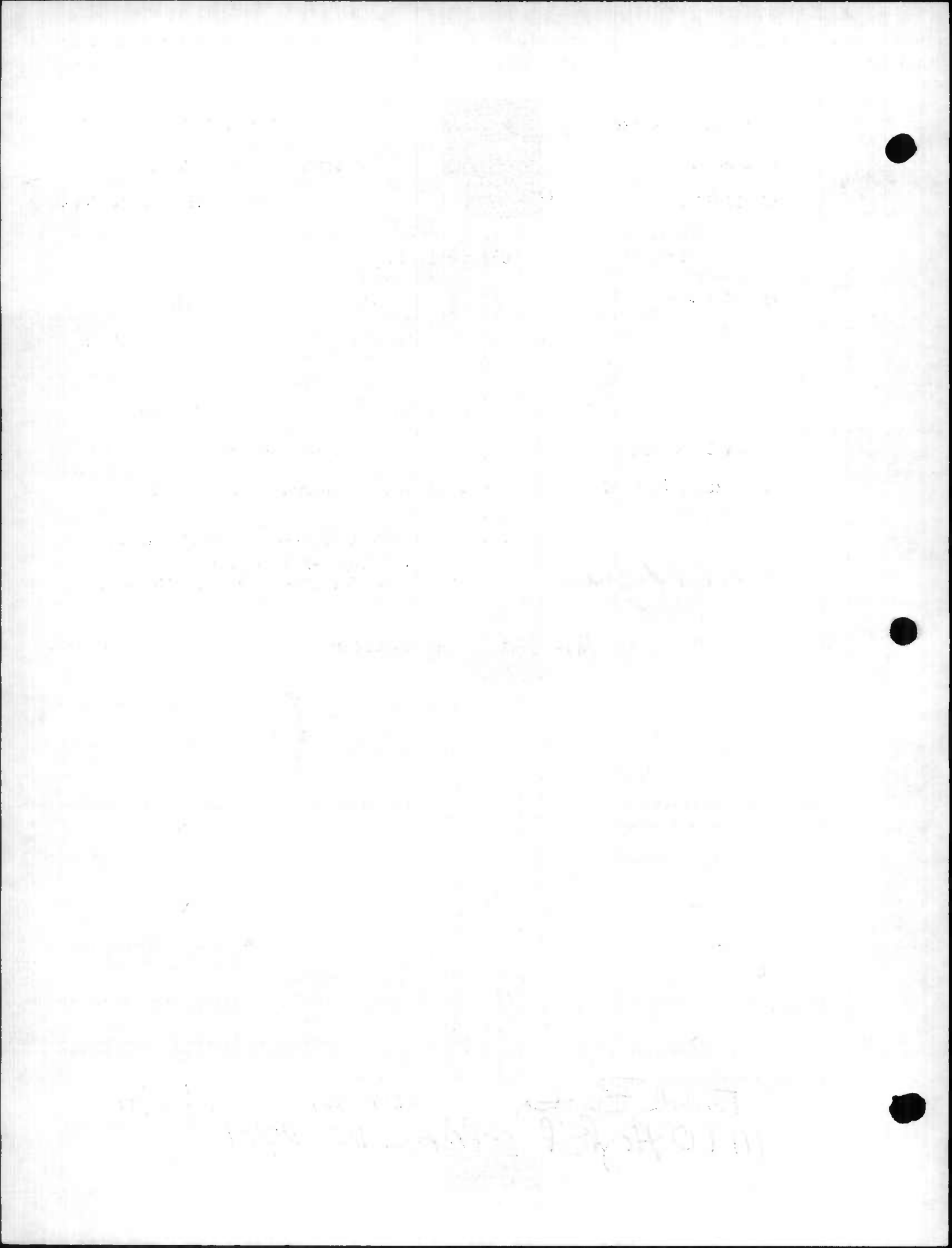
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

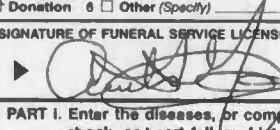
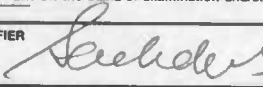
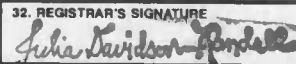
Medical Certification: To Be Completed by Physician/Medical Examiner



97 39988

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |   |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Lloyd Brock  |  |   |  | 2. DATE OF DEATH<br>MONTH 12 DAY 22 YEAR 97   |  | 3. TIME OF DEATH<br>4:57 p.m.   |   |
| 4. SOCIAL SECURITY NUMBER<br>467-05-0781   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 8. AGE (In yrs., last birthday)<br>86 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>08-15-1911   |   |
| 6a. FACILITY NAME (If not institution, give street and number)<br>MedPointe Continuous Care  |  |   |  | 6b. CITY, TOWN OR LOCATION OF DEATH<br>Elkton   |  | 6c. COUNTY OF DEATH<br>Cecil  |   |
| RESIDENCE OF DECEDENT  |  |   |  |   |  |   |   |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Cecil  |  | 10c. CITY, TOWN OR LOCATION<br>Elkton   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br>1 Price Drive  |  |   |  | 10f. ZIP CODE<br>21921  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12  |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Food Broker                        |  | 15b. KIND OF BUSINESS/INDUSTRY<br>Food Service  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Bowman L. Brock   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Nellie Massey  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Delores Smith  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>905 Gallatin Ct., Middletown, DE 19709   |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>L.O.O.F. Cemetery  |  | DATE<br>12-29-97  |  | 20c. LOCATION — City or Town, State<br>Rockdale, Texas  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Beeson Memorial Services<br>2053 Pulaski Hwy., Newark, DE 19702   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. - Coronary Artery Disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. - Atherosclerotic Heart Disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  |   | Approximate Interval Between Onset and Death<br>yrs<br>yrs.   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Hypertension, Hypertension   |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
|  |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  |   |   |
|  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |   |  | 29c. LICENSE NUMBER<br>D23322   |  | 29d. DATE SIGNED (Month, Day, Year)<br>12/23/97   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Sheelmohan Sachdev, 118 North Street, Elkton, Md 21921  |  |   |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>DEC 23 1997   |  |   |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

25% GOLD QUALIFIER

25% GOLD QUALIFIER



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39989

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Cover Brunt</b>   |  |   |  | 2. Date of Death<br>Month <b>Dec</b> Day <b>6</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>6:36 pm</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Anne Arundel Medical Center</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Annapolis</b>  |  | 4c. County of Death<br><b>Anne Arundel</b>   |  |
| 5. Social Security Number<br><b>119 - 07-1486</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>October 25, 1913</b>   |  |
| 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  | 10a. State<br><b>Florida</b>  |  | 10b. County<br><b>Pinellas</b>  |  | 10c. City, Town or Location<br><b>Dunedin</b>  |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>U.S. Navy WWII</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>School Teacher</b>                                      |  | 16b. Kind of Business/Industry<br><b>Public Junior High School</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Scherer Brunt</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Hilda Rose</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Gary G. Brunt / Son</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>910 Old County Road, Severna Park, MD 21146</b>                     |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Charlestown Cemetery</b>   |  | Date<br><b>Dec. 11 1997</b>   |  | 20c. Location - City or Town, State<br><b>Charlestown, Maryland</b>  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Crouch Funeral Home<br/>127 South Main Street, North East, MD 21901</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. arteriosclerotic coronary vascular disease</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. </b><br>Due to (or as a consequence of):<br><b>c. </b><br>Due to (or as a consequence of):<br><b>d. </b> |  |   |  | Approximate Interval Between Onset and Death<br><b>unknown</b>  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 28d. Describe how injury occurred  |  |   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D28640</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>Dec 7, 1997</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>2414 Hightee Ct. Crofton MD 21114</b>   |  |   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 10 1997</b>  |  | 32. Registrar's Signature<br>  |  |   |  |  |  |

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39990

|                                     |  |  |  |  |   |  |   |  |  |  |
|-------------------------------------|--|--|--|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Mary Estella BAER</b>   |  |  |  | 2. Date of Death<br>Month <b>December</b> Day <b>20</b> Year <b>1997</b>  |  |   |  | 3. Time of Death<br><b>9:03 PM</b>   |  |
|                                     | 4a. Facility Name (If not institution, give street and number)<br><b>Dennett Road Manor Nursing Home</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Oakland</b>  |  |   |  | 4c. County of Death<br><b>Garrett</b>  |  |
| Funeral<br>Director                 | 5. Social Security Number<br><b>220-10-1151</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>89</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>2/15/08</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |
|                                     | Usual Residence of Decedent  |  |  |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Garrett</b>                         |  | 10c. City, Town or Location<br><b>Oakland</b>  |  |
| To Be Completed by Funeral Director | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 10e. Street and Number<br><b>4396 Kempton Rd.</b>   |  |   |  | 10f. Zip Code<br><b>21550</b>  |  |
|                                     | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  |   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  |
|                                     | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)  |  |
|                                     | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Assembler</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>Electronics</b>  |  |   |  | 17. Father's Name (First, Middle, Last)<br><b>Emory Adolphus Lewis</b>   |  |
|                                     | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Estella ----- Lee</b>  |  |  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Marlene Koch/Daughter</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>139 Green Meadow Dr., Timonium, MD 21093</b>   |  |
|                                     | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garrett CO. Mem. Gardens</b>   |  |   |  | 20c. Location - City or Town, State<br><b>12/23 Oakland</b>  |  |
|                                     | 21. Signature of Funeral Service Licensee<br>  |  |  |  | 22. Name and Address of Facility<br><b>Stewart Funeral Home</b><br><b>32 S. Second St. Oakland, MD 21550</b>  |  |   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>a. atherosclerotic cardiovascular disease</b><br>Due to (or as a consequence of):<br><br><b>b. _____</b><br>Due to (or as a consequence of):<br><br><b>c. _____</b><br>Due to (or as a consequence of):<br><br><b>d. _____</b>   |  |
|                                     | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|                                     | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  |
|                                     | 28a. Date of Injury (Month, Day, Year)   |  |  |  | 28b. Time of Injury<br><b>M</b>   |  |   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 28d. Describe how injury occurred   |  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |
| Physician<br>/Medical<br>Examiner   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  | 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br><b>830035</b>   |  |
|                                     | 29d. Date signed (Month, Day, Year)<br><b>12-22-97</b>   |  |  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Donald R. Richter, 1533 Memorial Dr., OAkland, MD 21550</b>  |  |   |  | 31. Date filed (Month, Day, Year)<br><b>DEC 23 1997</b>  |  |
|                                     | 32. Registrar's Signature<br>   |  |  |  | 33. State Registrar   |  |   |  | 34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020  |  |
|                                     | 35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. |  |  |  | 36. To Be Completed by Physician/Medical Examiner   |  |   |  | 37. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. |  |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39991

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mildred Gladys Butler

2. Date of Death

Month  
12Day  
18Year  
97

3. Time of Death

6:05am

4a. Facility Name (If not institution, give street and number)

Caroline Nursing Home, Inc.

4b. City, Town, or Location of Death

Denton

4c. County of Death

Caroline

Funeral  
Director

5. Social Security Number

220-01-8696

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

(Month, Day, Year)  
November 3, 1904

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Caroline

10c. City, Town or Location

Denton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

152 Sunset Avenue

10f. Zip Code

21629

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:  
Caucasian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11 HS Grad.

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Legal

17. Father's Name (First, Middle, Last)

George Gilbert Breeding

18. Mother's Name (First, Middle, Maiden Surname)

Daisy Anna Scott

19a. Informant's Name/Relationship (Type, Print)

Harriet B. Seder

Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1945 Whitney Avenue, North Haven, Connecticut 06473

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Denton Cemetery

Date

12/20

20c. Location - City or Town, State

Denton, Maryland

21. Signature of Funeral Service Licensee

Charles Moore

22. Name and Address of Facility

Moore Funeral Home, P.A.

12 South Second Street, Denton, Maryland 21629

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

s. Congestive heart Failure

Approximate Interval Between Onset and Death

YMS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

coronary artery disease  
Organic brain Syndrome

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James Sideras

29c. License number

D31376

29d. Date signed (Month, Day, Year)

12-18-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

James Sideras 920 Market St Denton MD 21629

31. Date filed (Month, Day, Year)

DEC 18 '97

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39992

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Beatrice Gay Bonner

2. Date of Death

Month Day Year  
December 12 1997

3. Time of Death

9:10AM

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

577-60-7229

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb 18 1924

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Davidsonville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3913 Birdsville Road

10f. Zip Code

21035

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

Plus

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Federal Gov't Employee

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Asa Bonner

18. Mother's Name (First, Middle, Maiden Surname)

Melvina Flanagan

19a. Informant's Name/Relationship (Type, Print)

Thelma Eves (Neice)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

902 Bridgeport Court Annapolis, Maryland 21401

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Flanagan Hill Cemetery 12/16/97

Date

20c. Location - City or Town, State

Davis, West Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

John M. Taylor Funeral Home, Inc.  
147 Duke of Gloucester St. Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)a. Metastatic cancer of uterine cervix  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and DeathSeveral  
yearsSequitely list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. ———  
Due to (or as a consequence of):c. ———  
Due to (or as a consequence of):d. ———  
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 8 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D05928

29d. Date signed (Month, Day, Year)

December 12, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles W. Kinzer, MD, 2003 Medical Pkwy #100, Annapolis, MD 21401

State  
Registrar

31. Date filed (Month, Day, Year)

DEC 15 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

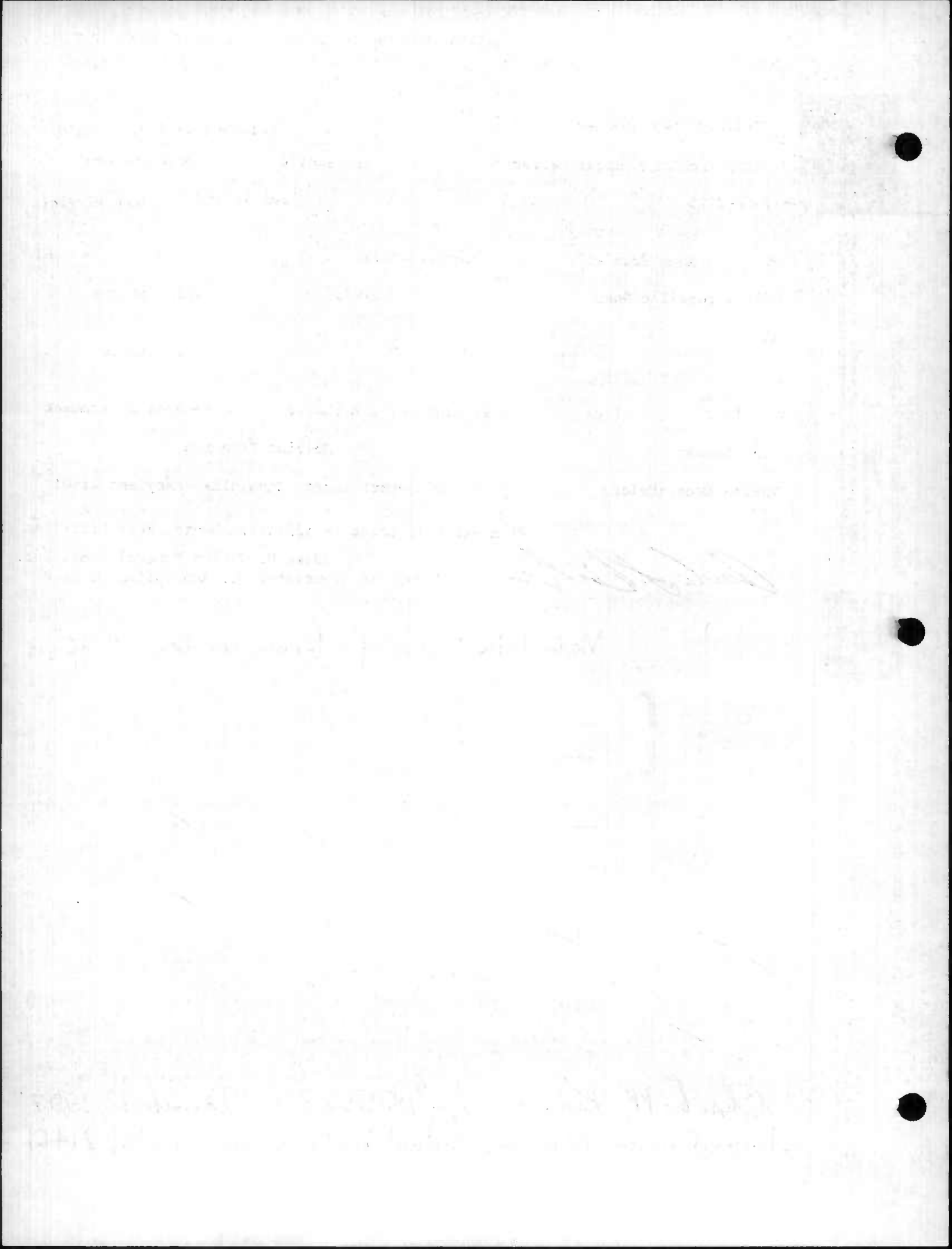
Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39993

|   |   |  |   |  |  |  |   |  |
|---|---|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Mary Stewart Belitz</b>  |  |   |  | 2. Date of Death<br>Month <b>December</b> Day <b>14</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>2:30PM</b>   |  |
|   | 4e. Facility Name (If not Institution, give street and number)<br><b>Genesis Elder Care Spa Creek Center</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Annapolis</b>   |  | 4c. County of Death<br><b>Anne Arundel</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>216-44-2090</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>April 14 1913</b>                                 |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10e. State<br><b>MD</b>   |  | 10b. County<br><b>Baltimore</b>  |  | 10c. City, Town or Location<br><b>Towson</b>  |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>503 Stratford Court</b>  |  | 10f. Zip Code<br><b>21204</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>                                       |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>School Teacher</b>                |  | 16b. Kind of Business/Industry<br><b>Education</b>   |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>George H. Lewis</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary W. (unknown)</b>  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>George Belitz (Son)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1001 Dreams Landing Way Annapolis, Maryland 21401</b>                                    |  |   |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Ft. Lincoln Crematory</b>  |  | 20c. Location - City or Town, State<br><b>Brentwood, Maryland</b>  |  | 20d. Date<br><b>12/16/97</b>  |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>John M. Taylor Funeral Home, Inc.<br/>147 Duke of Gloucester St. Annapolis, MD 21401</b>  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Alzheimer's Disease</b><br>Due to (or as a consequence of):<br>f.<br>Due to (or as a consequence of):<br>g.<br>Due to (or as a consequence of):<br>h.<br>Due to (or as a consequence of):<br>i.<br>Due to (or as a consequence of):<br>j.<br>Due to (or as a consequence of):<br>k.<br>Due to (or as a consequence of):<br>l.<br>Due to (or as a consequence of):<br>m.<br>Due to (or as a consequence of):<br>n.<br>Due to (or as a consequence of):<br>o.<br>Due to (or as a consequence of):<br>p.<br>Due to (or as a consequence of):<br>q.<br>Due to (or as a consequence of):<br>r.<br>Due to (or as a consequence of):<br>s.<br>Due to (or as a consequence of):<br>t.<br>Due to (or as a consequence of):<br>u.<br>Due to (or as a consequence of):<br>v.<br>Due to (or as a consequence of):<br>w.<br>Due to (or as a consequence of):<br>x.<br>Due to (or as a consequence of):<br>y.<br>Due to (or as a consequence of):<br>z.<br>Due to (or as a consequence of):<br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>Approximate Interval Between Onset and Death<br><b>3 yrs.</b> |  |   |  |  |  |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |   |  |  |  |   |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |   |  |  |  |   |  |
| Physician<br>/Medical<br>Examiner   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |   |  |
|   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |  |  |  |   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|   | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |  |   |  |
|   | 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br><b>D25499</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>12/15/97</b>                                      |  |
|   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>James W. Ruppel 180 Admiral Cochrane Dr Annapolis, MD 21401</b>  |  |   |  |  |  |   |  |
|   | 31. Date filed (Month, Day, Year)<br><b>DEC 16 1997</b>   |  |   |  | 32. Registrar's Signature<br>  |  |   |  |



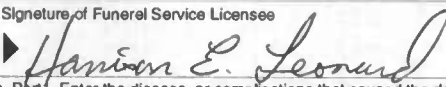
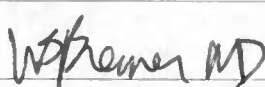
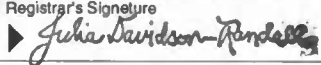
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 39994

|  |  |   |   |  |  |  |  |  |  |  |
|--|--|---|---|--|--|--|--|--|--|--|
| <b>Physician<br/>/Medical<br/>Examiner</b> | 1. Decedent's Name (First, Middle, Last)<br><b>GEORGE AUSTIN BRIDGES</b>   |   |   |  |  | 2. Date of Death<br>Month Day Year<br><b>Dec. 14, 1997</b>   |  | 3. Time of Death<br><b>12:10 A.M.</b>  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Memorial Hospital</b>   |   |   |  |  | 4b. City, Town, or Location of Death<br><b>Easton</b>  |  | 4c. County of Death<br><b>Talbot</b>   |  |  |
| <b>Funeral<br/>Director</b>                | 5. Social Security Number<br><b>214-05-2532</b>  |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>July 4, 1915</b>                           |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |
|  | Usual Residence of Decedent  |   |   |  |  |  |  |  |  |  |
| <b>To Be Completed by Funeral Director</b> | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Talbot</b>  |  | 10c. City, Town or Location<br><b>Bozman</b>   |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|  | 10e. Street and Number<br><b>7848 Cooper Point Road</b>  |   |   |  |  | 10f. Zip Code<br><b>21612</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No <b>WWII Army</b><br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>Postmaster Waterman</b>   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Postmaster Waterman</b>  |  |  | 16b. Kind of Business/Industry<br><b>Postal Service Seafood</b>  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Richard Austin Bridges</b>   |   |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Eva Jump</b>   |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Margaret Ann Bridges Wife</b>   |   |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7848 Cooper Pt. Rd. P.O. Box 217 Bozman, Md. 21612</b> |  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Bozman Cemetery</b>  |  |  | 20c. Date<br><b>Dec. 16, 1997</b>  |  | 20d. Location - City or Town, State<br><b>Bozman Maryland</b>  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>  |   |   |  |  | 22. Name and Address of Facility<br><b>Harrison E. Leonard Funeral Home<br/>312 S. Talbot St. St. Michaels, Maryland 21663</b>                             |  |  |  |  |
|  | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |  |  |  |  |  |  |  |
|  | <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>CONGESTIVE HEART FAILURE</b></p> <p>Due to (or as a consequence of):</p> <p>b. <b>ISCHEMIC CARDIOMYOPATHY</b></p> <p>Due to (or as a consequence of):</p> <p>c. </p> <p>Due to (or as a consequence of):</p> <p>d. </p> </div> <div style="width: 35%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p><b>YEARS</b></p> <p>↓</p> </div> </div> |   |   |  |  |  |  |  |  |  |
| <b>Physician<br/>/Medical<br/>Examiner</b> | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>VENTRICULAR TACHYCARDIA</b>   |   |   |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |
|  |  |   |   |  |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |
|  |  |   |   |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 28. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how Injury occurred  |  |
|  |  |   | 28a. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                       |  |
|  | 29e. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |  |  |  |  |  |  |  |
|  | 29b. Signature and title of certifier<br>   |   |   |  |  | 29c. License number<br><b>D26350</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>12/15/97</b>   |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>William S. Bremer M.D. 800 S. Talbot St. St. Michaels, Maryland 21663</b>   |   |   |  |  |  |  |  |  |  |
|  | <b>State<br/>Registrar</b>   | 31. Date filed (Month, Day, Year)<br><b>DEC 22 1997</b> |   | 32. Registrar's Signature<br> |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 97 39995

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM McDANIEL BRINSFIELD, SR.

2. Date of Death

Month Day Year  
DEC 18 1997

3. Time of Death

1:47 PM

4e. Facility Name (If not Institution, give street and number)

THE MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

EASTON

4c. County of Death

TALBOT

Funeral  
Director

5. Social Security Number

215-36-2499

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

85

if Under 1 Year

Months Days

if Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
OCT. 19, 1912

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

TALBOT

10c. City, Town or Location

CORDOVA

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

12899 CHURCH LANE

10f. Zip Code

21625

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DAIRY FARMER

16b. Kind of Business/Industry

FARMING

17. Father's Name (First, Middle, Last)

CARROLL SEDGEWICK BRINSFIELD

18. Mother's Name (First, Middle, Maiden Surname)

ALICE MAY NEWNAM

19a. Informant's Name/Relationship (Type, Print)

KATHRYN C. BRINSFIELD/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12899 CHURCH LANE, CORDOVA, MD 21625

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SPRING HILL CEMETERY

Date

12-22

20c. Location - City or Town, State

EASTON, MD

21. Signature of Funeral Service Licensee

M. E. Newnam DCFSP

22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME  
200 S. HARRISON ST., EASTON, MD 21601

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory failure

Due to (or as a consequence of):

b. Pneumonia

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 weeks

2 weeks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No25. Was case referred to medical examiner?  
☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

28. Place of Death (Check only one)

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☐ Natural ☐ Pending investigation  
☐ Accident ☐ Suicide  
☐ Homicide ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Thomas W. Fauntleroy, M.D.

29c. License number

015-315

29d. Date signed (Month, Day, Year)

12-19-97

30. Name and address of person who completed cause of death (Item 23b) (Type, Print)

THOMAS W. FAUNTLEROY, M.D., 403 MARVEL CT., EASTON, MD 21601

31. Date filed (Month, Day, Year)

DEC 19 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
RegistrarWILLIAM BRINSFIELD  
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39996

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

THOMAS ISADORE BOYLE

2. Date of Death

DEC. 17 1997

3. Time of Death

7:30 AM

4a. Facility Name (If not institution, give street and number)

GENESIS ELDERCARE-CORSICA HILLS

4b. City, Town, or Location of Death

CENTREVILLE

4c. County of Death

QUEEN ANNE

Funeral  
Director

5. Social Security Number

217-16-9004

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

JUNE 6, 1914 MARYLAND

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

QUEEN ANNE

10c. City, Town or Location

QUEEN ANNE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

730 FOX MEADOW ROAD

10f. Zip Code

21657

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

ARMY

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

FARMER

16b. Kind of Business/Industry

FARMING

17. Father's Name (First, Middle, Last)

CHARLES ISADORE BOYLE

18. Mother's Name (First, Middle, Maiden Surname)

MARGARET EGAN

19a. Informant's Name/Relationship (Type, Print)

RITA B. MIELKE/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

808 FOX MEADOW RD. QUEEN ANNE, MD 21657

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ST. JOSEPH CEMETERY

Date

12-19 CORDOVA, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

JOHN R. MERGERON

22. Name and Address of Facility

FELLOWS, HELFENBEIN &amp; NEWNAM FUNERAL HOME

200 S. HARRISON ST., EASTON, MD 21601

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. prostate CA Due to (or as a consequence of):

b. dehydration Due to (or as a consequence of):

c. congestive heart failure Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

months

weeks

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

coronary artery disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Kathleen Hoey

29c. License number

D47627

29d. Date signed (Month, Day, Year)

12-17-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KATHLEEN HOEY, M.D., 207 N. LIBERTY ST., CENTREVILLE, MD 21617

31. Date filed (Month, Day, Year)

DEC 18 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

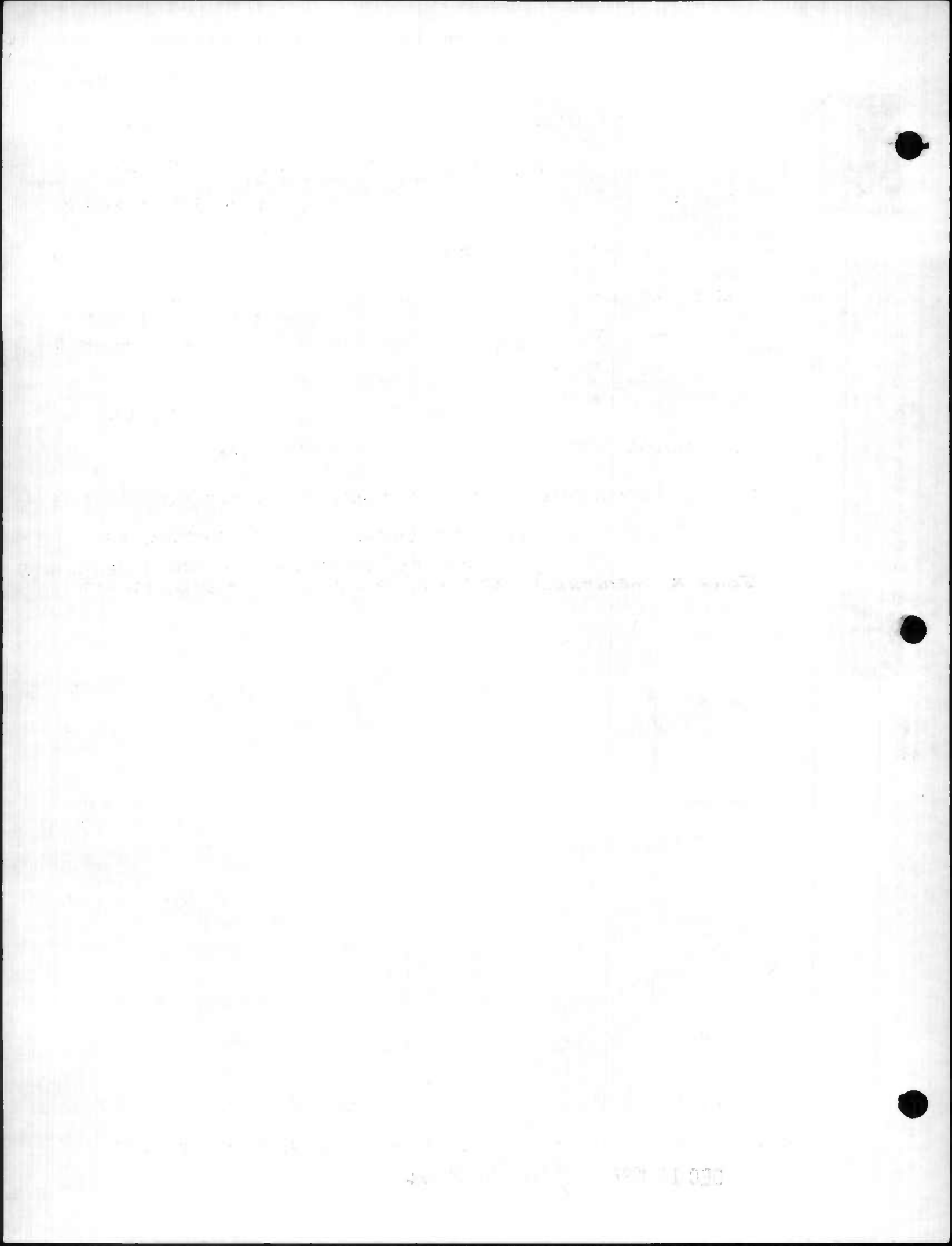
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



DEC 14 1957

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 39997

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

TERESA ROSA BISSO

2. Date of Death

Month

Day

Year

12

14

97

3. Time of Death

0400

4a. Facility Name (If not institution, give street and number)

GENESIS ELDERCARE-CHESAPEAKE WOODS CTR CAMBRIDGE

4b. City, Town, or Location of Death

4c. County of Death

DORCHESTER

Funeral  
Director

5. Social Security Number

215-62-0253

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

97

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

SEPT. 4, 1900

9. Birthplace (State or Foreign Country)

PERU

Usual Residence of Decedent

10a. State

MD

10b. County

DORCHESTER

10c. City, Town or Location

CAMBRIDGE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

520 GLENBURN AVENUE

10f. Zip Code

21613

10g. Citizen of What Country?

PERU

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☒ Yes 2 ☐ No Specify: PERUVIAN

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4 or 5+)

-0-

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

JUAN BAUTISTA BISSO

18. Mother's Name (First, Middle, Maiden Surname)

GREGORIA MAGNI

19a. Informant's Name/Relationship (Type, Print)

MARIA COVEY/GRANDDAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7075 SYCAMORE LANE, EASTON, MD 21601

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Data

20c. Location - City or Town, State

WOODLAWN MEMORIAL PARK 12-16 EASTON, MD

21. Signature of Funeral Service Licensee

Maurice E. Munroe IV

22. Name and Address of Facility

FELLOWS, HELFENBEIN &amp; NEWNAM FUNERAL HOME

200 S. HARRISON ST., EASTON, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Chronic Debilitated State

Due to (or as a consequence of):

5 yrs

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Michael F. Finken MO 302 Collins Hurlock MD 21643

29c. License number

D 26388

29d. Date signed (Month, Day, Year)

12/14/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

DEC 15 1997

32. Registrar's Signature

Fika Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item #28f, Per Phy. State of Maryland / Department of Health and Mental Hygiene  
12/17/97, Carroll County, wjl

Certificate of Death

Reg. No.

37 39998

|   |  |  |  |  |  |  |   |   |
|---|--|--|--|--|--|--|---|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><i>Christopher Costello</i>                              |  |  |  | 2. Date of Death<br>Month <i>December</i> Day <i>12</i> Year <i>1997</i> |  | 3. Time of Death<br><i>3:00pm</i>                         |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><i>Sinai Hospital of Baltimore</i> |  |  |  | 4b. City, Town, or Location of Death<br><i>Baltimore</i>                 |  | 4c. County of Death<br><i>Baltimore City</i>              |   |
| Funeral<br>Director   | 5. Social Security Number<br><i>219-74-3814</i>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><i>37</i> Yrs.                         |  | 8. Date of Birth (Month, Day, Year)<br><i>Oct 9, 1960</i> |   |
|   | 9. Birthplace (State or Foreign Country)<br><i>Maryland</i>  |  | 10a. State<br><i>MD</i>  |  | 10b. County<br><i>Carroll</i>  |  | 10c. City, Town or Location<br><i>Sykesville</i>          |   |
| Usual Residence of Decedent   |  |  |  |  |  |  |   |   |
| 10a. State<br><i>MD</i>   |  |  | 10b. County<br><i>Carroll</i>  |  |  | 10c. City, Town or Location<br><i>Sykesville</i>   |   |   |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  | 10e. Street and Number<br><i>3832 London Bridge Road</i>   |  |  | 10f. Zip Code<br><i>21784</i>  |   |   |
| 10g. Citizen of What Country?<br><i>U.S.A.</i>  |  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:    |   |   |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i>  |  |  | 15. Decedent's Education (Specify only highest grade completed)<br><i>Elementary/Secondary (0-12)</i> <i>Collage (1-4or 5+)</i><br><i>12</i>         |   |   |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Painter</i>   |  |  | 16b. Kind of Business/Industry<br><i>Home Improvement</i>  |  |  | 17. Father's Name (First, Middle, Last)<br><i>Charles C. Costello</i>  |   |   |
| 18. Mother's Name (First, Middle, Maiden Sumame)<br><i>Shirley J. Duffy</i>   |  |  | 19a. Informant's Name/Relationship (Type, Print)<br><i>Mrs. Karen J. Costello (Wife)</i>   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>3832 London Bridge Road Sykesville, MD 21784</i> |   |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Carroll Cremation Serv.</i>   |  |  | 20c. Location - City or Town, State<br><i>12/15/97 Hampstead, MD</i>   |   |   |
| 21. Signature of Funeral Service Licensee<br><i>Brian A. Haight</i>   |  |  | 22. Name and Address of Facility<br><i>HAIGHT FUNERAL HOME &amp; CHAPEL (Box 195)<br/>Sykesville, MD 21784 (410)-795-1400</i>  |  |  |  |   |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><i>a. Subdural Hematoma</i><br>Due to (or as a consequence of):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><i>b. Due to (or as a consequence of):</i><br><i>c. Due to (or as a consequence of):</i><br><i>d. Due to (or as a consequence of):</i> |  |  |  |  |  |  |   |   |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |  |  |  |  |   |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |  |  |  |   |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |  |  |  |   |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |  |  |  |   |   |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  |  |  |  |   |   |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  |  | 28a. Date of Injury (Month, Day, Year)<br><i>12/11/97</i>  |  |  | 28b. Time of Injury<br><i>1600</i> M   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 28d. Describe how injury occurred<br><i>Family found pt. unconscious, had been drinking</i>   |  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)<br><i>Westminster, MD</i>   |  |  |  |   |   |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |  |  |  |  |   |   |
| 29b. Signature and title of certifier<br><i>[Signature] MD</i>  |  |  | 29c. License number<br><i>P11600</i>   |  |  | 29d. Date signed (Month, Day, Year)<br><i>December, 12, 1997</i>   |   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>S. Skinner, Surgery, J.Hs Hopkins Hosp, 600 N. Wolfe St., BALTIMORE MD, 21287</i>  |  |  |  |  |  |  |   |   |
| 31. Date filed (Month, Day, Year)<br><i>DEC 17 1997</i>   |  |  | 32. Registrar's Signature<br><i>[Signature]</i>  |  |  |  |   |   |

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 39999

## Certificate of Death

Reg. No.

|  |   |                               |   |   |  |   |  |  |
|--|---|-------------------------------|---|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>John Francis Chick, SR.</b>                          |                               |   |   | 2. Date of Death<br>Month <b>Dec</b> Day <b>19</b> Year <b>1997</b>  |   | 3. Time of Death<br><b>6:05 A.M.</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Southern Maryland Hospital</b> |                               |   |   | 4b. City, Town, or Location of Death<br><b>Clinton</b>   |   | 4c. County of Death<br><b>Prince George's</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>578-24-5462</b>   |                               | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>72</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>OCTOBER 15, 1925</b>                                 | 9. Birthplace (State or Foreign Country)<br><b>WASHINGTON DC</b>   |
|  | Usual Residence of Decedent   |                               |   |   |  |   |  |  |
| 10a. State<br><b>MARYLAND</b>  |   | 10b. County<br><b>CHARLES</b> |   | 10c. City, Town or Location<br><b>HUGHESVILLE</b>   |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>6760 MERRI-A-LEE WAY</b>  |   |                               |   | 10f. Zip Code<br><b>20637</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                            |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   |                               | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1942-1946</b>  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |   |                               |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>MANAGER</b> |  | 16b. Kind of Business/Industry<br><b>BELL ATLANTIC TELECOMMUNICATIONS</b> |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>HARRY ALBERTUS CHICK</b>   |   |                               |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARY CATHERINE MOLLOY</b>  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>DOROTHY ANN CHICK, SPOUSE</b>   |   |                               |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6760 MERRI-A-LEE WAY, HUGHESVILLE, MD 20637</b>  |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |                               | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ST. MARY'S CHURCH CEMETERY</b>   |   | 20c. Location - City or Town, State<br><b>12/22/97 BRYANSTOWN, MD</b>  |   |  |  |
| 21. Signature of Funeral Service Licensee<br><b>MARK G. BROHAWN</b>  |   |                               | 22. Name and Address of Facility<br><b>THE HUNTT FUNERAL HOME, INC., POST OFFICE BOX 156, WALDORF, MD 20604</b>   |   |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Recurrent Sepsis</b><br><b>Cirrhosis</b><br><b>Thrombocytopenia</b>  |   |                               |   |   |  |   |  | Approximate Interval Between Onset and Death<br><b>10 days</b>   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Renal Failure</b><br><b>Hemodialysis</b><br><b>Thrombocytopenia</b>   |   |                               |   |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |                               |   |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |                               | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   |                               | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  |
|  |   |                               | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  | 28d. Describe how injury occurred   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |                               | 29b. Signature and title of certifier<br><b>Michael D. Levine</b>   |   | 29c. License number<br><b>D24945</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>December 20, 1997</b>                                |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Michael D. Levine, 7801 Old Branch Avenue, #409, Clinton, Maryland 20735</b>  |   |                               |   |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>DEC 23 1997</b>  |   |                               | 32. Registrar's Signature<br><b>John Andrew Randall</b>   |   |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 40000

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mildred Virginia Cheatham

2. Date of Death

Month Day Year  
DECEMBER 12 1997

3. Time of Death

18:33

4a. Facility Name (If not institution, give street and number)

MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

Funeral  
Director

5. Social Security Number

232-52-0699

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Apr 3, 1932

9. Birthplace (State or Foreign Country)

WV

Usual Residence of Decedent

10a. State

WV

10b. County

Marshall

10c. City, Town or Location

Moundsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

RD #5, Box 125

10f. Zip Code

26041

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

Unknown

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

James Hall

18. Mother's Name (First, Middle, Maiden Surname)

Pearl Minor

19a. Informant's Name/Relationship (Type, Print)

Debra Heintzman

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3381 South Roberts Rd., Fredonia, NY 14063

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Riverview Cemetery

Date

Dec. 16 1997

20c. Location - City or Town, State

Moundsville, WV

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Grisell Funeral Home

400 Jefferson Ave., Moundsville, WV 26041

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 1/2 weeks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D35481

29d. Date signed (Month, Day, Year)

DECEMBER 12, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. MARK SAGIN, MEMORIAL HOSPITAL, SUITE 400, CUMBERLAND, MD 21502

31. Date filed (Month, Day, Year)

DEC 18 1997

32. Registrar's Signature

John H. Hester

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

MILDRED CHEATHAM

232-52-0699

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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